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Stanford

LPCH APP Preceptor Workshop Handbook

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Objectives:

At the end of the workshop, attendees will be able to:

- Understand preceptor roles and responsibilities
- Describe how to assess the preceptee's learning needs
- Demonstrate how to promote critical thinking skills in their preceptee
- Describe strategies to communicate/give feedback effectively
- Apply knowledge, skills, and attitudes gained from this workshop to the preceptor role

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Contents:

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PART ONE

LEARN

Unique strategies for a unique you!

We teach and learn differently.

How do YOU do it?

Heidi Terwey, PA-C

Lucile Packard Children's Hospital Stanford

PART 1

Honey and Mumford Assessment

The Ultimate Goal: Effective learning

What makes a learning experience good or effective?

1. The learning "sticks."
2. Learning gets used appropriately, and is useful.
3. When put to use, it makes a difference for the BETTER.

To be the "best" preceptor…

- To be an effective educator it is not enough to be a content expert alone.
- Adults learn through experience and by reflecting on their experiences with the assistance of a trusted coach or facilitator.
- Educators must understand how adults learn best and how to facilitate their learning.

Define how your student learns, and adapt to their style…

- Learning styles were developed by Peter Honey and Alan Mumford.
- They identified four distinct learning styles or preferences: Activist, Theorist, Pragmatist, and Reflector.
- Seek out opportunities to *teach* using that style.

Let's take the test to see what type of learner we are!

https://www.eln.io/blog/honey-mumford-learner-types-1986-questionnaire-online

- Allow 10-15 minutes for exam, then hit submit and see what type of learner you are.
- Return to slide presentation once complete.

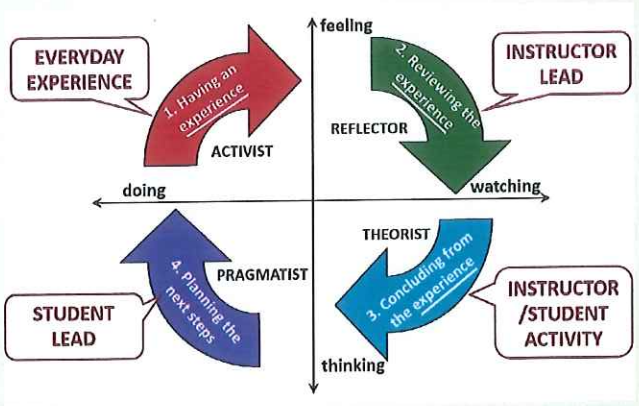
PART 2

What type of learner are you and what does it mean?

Four Types of Learners

- Activist
- Theorist
- Pragmatist
- Reflector

Types of Learners:



https://realizeengineering.blog/tag/learning-s

Types of Learners:

- Through studies conducted in the U.K. on adult learners, surgeons are most often categorized as "Activists or Pragmatists."
- Non-surgical trained MDs often fell in to the "Theorist or Reflector" category.
- Men were also more likely to have an Activist or Pragmatist style.
- Women more likely to be Reflector or Theorist.

Activist:

Activists are those individuals who learn by doing. Activists need to get their hands dirty. They have a receptive way to deal with learning, including themselves completely and without inclination in new encounters. The learning activities can be brainstorming, problem solving, group discussion, puzzles, competitions, role-play etc.

Activist-Case Study

- "See one, do one, teach one..."
- Kyle is a PA Student who is in his last year of training. He joins your team for a one month elective rotation in Pediatric Anesthesia. As an observer, he seems bored and disinterested in his clinical rotation, and disconnects when asked to perform chart reviews. He thrives in the Operating Room when asked to place lines, assist with intubations, and move quickly between cases that are new to him.

ACTIVISTS:

- Activists learn best when:
  - They are involved in new experiences, problems and opportunities
  - They are thrown in at the deep end
  - They can work with others in problem solving, games, role-playing exercises
  - They are able to lead a group

ACTIVISTS:

- Activists learn least when:
  - listening to lectures or reading long explanations
  - reading, writing and thinking on their own
  - analyzing and interpreting lots of data
  - following precise instructions

Theorist:

These learners get a kick out of the chance to comprehend the hypothesis behind the activities. They require models, ideas and truths with a specific end goal to participate in the learning procedure. Like to break down and integrate, drawing new data into a methodical and consistent 'hypothesis'. Their choice of learning activities includes models, statistics, stories, quotes, background information, applying concepts theoretically etc.

Theorist-Case Study

- Data driven
- Ellen is an experienced Nurse Practitioner in Pediatric Pain Clinic, and she is learning about developing an APP driven Regional Block program. The data provides evidence that Ellen's patients will benefit from reduction in opioid consumption, as well as reduced pain and time to discharge and better quality of life in the immediate postoperative period. She is spending a lot of time preparing her team for the increase in clinical practice and is stressed because administration is pressuring her to get the program rolling ASAP.

THEORISTS:

- Theorists learn best when:
  - They can participate in an activity is backed up by ideas and concepts that form a model, system, or theory
  - They are in a structured situation with a clear purpose
  - They have the chance to question and probe
  - They are required to understand a complex situation

THEORISTS:

- Theorists learn least:
  - When in situations that emphasize emotions and feelings
  - When activities are unstructured or ambiguous
  - When asked to act without knowing the principles or concepts involved

Pragmatist:

These individuals have the capacity to perceive how to put the learning into practice in their present reality. Conceptual ideas and recreations are of constrained utility unless they can see an approach to put the concepts practically in their lives. Experimenting with new ideas, speculations and methods to check whether they work is their mode of action. They learn better through taking time to think about how to apply learning in reality, case studies, problem solving and discussion.

Pragmatist-Case Study

- Surgical minded with proven techniques
- Hans is a Nurse Practitioner who works on the Renal Transplant team. He is well known for his clinical expertise and has been working at his institution for 25 years. He is familiar with cutting edge surgical techniques in his specialty and has even trained in some of them, yet he is more comfortable with the work he's been doing over the past several years as a standard of care. He's happy to take some of the new technology and applies it to his current clinical practice to see what "sticks."

PRAGMATISTS:

- Pragmatists learn best when:
  - There is an obvious link between the topic and a current need
  - They are shown techniques with clear practical advantages
  - They can try things out with feedback from an expert
  - They can copy an example, or emulate a role model

PRAGMATISTS:

- Pragmatists learn least when:
  - There is no immediate practical benefit
  - There are no clear guidelines on how to do it
  - It appears to be 'all theory'

Reflector:

These individuals learn by watching and contemplating what happened. They may abstain from jumping in and prefer to watch from the sidelines. They want to remain back and see encounters from various alternate points of view, gathering information and using the opportunity to work towards a suitable conclusion. They like paired discussions, self-analysis questionnaires, personality questionnaires, time out, observing activities, feedback from others. coaching, interviews etc.

Reflector-Case Study

- Jen is a new graduate PA on the Peds Heart Failure service. Early in her orientation period, when asked to initiate a clinic visit, she is obviously uncomfortable and feels unprepared. She asks to shadow more frequently than other new hires, and prefers to observe from the sidelines. When asked about her patient encounter, she is able to recite back key moments of the visit and can effectively articulate a plan.

REFLECTORS:

- Reflectors learn best when:
  - They are able to stand back and observe first
  - They are given time to think and investigate before commenting or acting
  - They are given an opportunity to review what has happened
  - They can do tasks without tight deadlines

REFLECTORS:

- Reflectors learn least when:
  - They are forced to take a lead in a group
  - Doing things without preparation
  - They are rushed by deadlines

Define how your student learns, and adapt to their style…

- Honey and Mumford gave a questionnaire that probes general behavioral tendencies. The rationale behind this is that most people have never consciously considered how they really learn. And to be an effective learner, individuals must know about their learning styles or preferences and find ways to learn using those methods.
- Knowing your learning style helps individuals to make smarter decisions in adjusting the learning opportunities and your preference of best learning, increases the range and variety of experiences which are potential learning opportunities, improves learning skills and awareness (Zwanenberg, 2016).

Why Learn how to Learn?

- Another tool in our toolbox
- Think about learning as a skill, that we can continually strive to improve
- Results depend on the process

Key Take-aways:

- We prefer to learn in different ways
- No preferred learning style
- Knowing your style will help learning and teaching be more effective
- We are usually a combination of all types and are capable of using any technique
- Gives us the opportunity to focus on areas that we are less strong in to make us more balanced

Teachers affect eternity; no-one can tell where their influence stops.

Henry Brooks Adams

Resources:

- Honey, P. & Mumford, A. (1982) Manual of Learning Styles London: P Honey
- Leaver, B. (2005). Learning styles and learning strategies (Chapter 3) – Achieving Success in Second Language Acquisition. [online] Cambridge Core.
- Mobbs, D. (2010). Honey and Mumford — University of Leicester. [online]
- Pd-how2.org. (2016). Learning styles. [online]
- Zwanenberg, N. (2016). Felder and Silverman's Index of Learning Styles and Honey and Mumford's Learning Styles Questionnaire: How do they compare and do they predict academic performance?: Educational Psychology: Vol 20, No 3. [online]
- Learning Styles. Jon Rosewell. Open University @ www.open.edu
- (JH-Adult Learning Principals). *www2.le.ac.uk › departments › training › eresources › teaching › theories*
- How academic knowledge can support practice learning: A case study of learning styles. By Patricia Cartney, Journel of Practice Teaching 5(2) 2004, pp 51-72
- THE ROYAL COLLEGE OF SURGEONS OF ENGLAND BULLETIN. DOi: 10.1308/147363512X13311314197176

Thank You!

Any feedback or comments are welcome at APPStudentPlacement@stanfordchildrens.org

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Honey and Mumford: Learning Styles Questionnaire

There is no time limit to this questionnaire. It will probably take you 10-15 minutes. The accuracy of the results depends on how honest you can be. There are no right or wrong answers. If you agree more than you disagree with a statement put a tick. If you disagree more than you agree put a cross by it. Be sure to mark each item with either a tick or cross. When you have completed the questionnaire, continue this task by responding to the points that follow.

- ☐ 1. I have strong beliefs about what is right and wrong, good and bad.
- ☐ 2. I often act without considering the possible consequences.
- ☐ 3. I tend to solve problems using a step-by-step approach.
- ☐ 4. I believe that formal procedures and policies restrict people.
- ☐ 5. I have a reputation for saying what I think, simply and directly.
- ☐ 6. I often find that actions based on feelings are as sound as those based on careful thought and analysis.
- ☐ 7. I like the sort of work where I have time for thorough preparation and implementation.
- ☐ 8. I regularly question people about their basic assumptions.
- ☐ 9. What matters most is whether something works in practice.
- ☐ 10. I actively seek out new experiences.
- ☐ 11. When I hear about a new idea or approach I immediately start working out how to apply it in practice.
- ☐ 12. I am keen on self-discipline such as watching my diet, taking regular exercise, sticking to a fixed routine etc.
- ☐ 13. I take pride in doing a thorough job.
- ☐ 14. I get on best with logical, analytical people and less well with spontaneous, "irrational" people.
- ☐ 15. I take care over the interpretation of data available to me and avoid jumping to conclusions.
- ☐ 16. I like to reach a decision carefully after weighing up many alternatives.
- ☐ 17. I'm attracted more to novel, unusual ideas than to practical ones.
- ☐ 18. I don't like disorganised things and prefer to fit things into a coherent pattern.
- ☐ 19. I accept and stick to laid down procedures and policies so long as I regard them as an efficient way of getting the job done.
- ☐ 20. I like to relate my actions to a general principle.
- ☐ 21. In discussions I like to get straight to the point.
- ☐ 22. I tend to have distant, rather formal relationships with people at work.
- ☐ 23. I thrive on the challenge of tackling something new and different.
- ☐ 24. I enjoy fun-loving, spontaneous people.

☐ 25. I pay meticulous attention to detail before coming to a conclusion.

☐ 26. I find it difficult to produce ideas on impulse.

☐ 27. I believe in coming to the point immediately.

☐ 28. I am careful not to jump to conclusions too quickly.

☐ 29. I prefer to have as many sources of information as possible -the more data to mull over the better.

☐ 30. Flippant people who don't take things seriously enough usually irritate me.

☐ 31. I listen to other people's point of view before putting my own forward.

☐ 32. I tend to be open about how I'm feeling.

☐ 33. In discussions I enjoy watching the manoeuvrings of the other participants.

☐ 34. I prefer to respond to events on a spontaneous, flexible basis rather than plan things out in advance.

☐ 35. I tend to be attracted to techniques such as network analysis, flow charts, branching programmes, contingency planning, etc.

☐ 36. It worries me if I have to rush out a piece of work to meet a tight deadline.

☐ 37. I tend to judge people's ideas on their practical merits.

☐ 38. Quiet, thoughtful people tend to make me feel uneasy.

☐ 39. I often get irritated by people who want to rush things.

☐ 40. It is more important to enjoy the present moment than to think about the past or future.

☐ 41. I think that decisions based on a thorough analysis of all the information are sounder than those based on intuition.

☐ 42. I tend to be a perfectionist.

☐ 43. In discussions I usually produce lots of spontaneous ideas.

☐ 44. In meetings I put forward practical realistic ideas.

☐ 45. More often than not, rules are there to be broken.

☐ 46. I prefer to stand back from a situation and consider all the perspectives.

☐ 47. I can often see inconsistencies and weaknesses in other people's arguments.

☐ 48. On balance I talk more than I listen.

☐ 49. I can often see better, more practical ways to get things done.

☐ 50. I think written reports should be short and to the point.

☐ 51. I believe that rational, logical thinking should win the day.

☐ 52. I tend to discuss specific things with people rather than engaging in social discussion.

☐ 53. I like people who approach things realistically rather than theoretically.

☐ 54. In discussions I get impatient with irrelevancies and digressions.

☐ 55. If I have a report to write I tend to produce lots of drafts before settling on the final version.

☐ 56. I am keen to try things out to see if they work in practice.

☐ 57. I am keen to reach answers via a logical approach.

☐ 58. I enjoy being the one that talks a lot.

☐ 59. In discussions I often find I am the realist, keeping people to the point and avoiding wild speculations.

☐ 60. I like to ponder many alternatives before making up my mind.

☐ 61. In discussions with people I often find I am the most dispassionate and objective.

☐ 62. In discussions I'm more likely to adopt a "low profile" than to take the lead and do most of the talking.

☐ 63. I like to be able to relate current actions to a longer-term bigger picture.

☐ 64. When things go wrong I am happy to shrug it off and "put it down to experience".

☐ 65. I tend to reject wild, spontaneous ideas as being impractical.

☐ 66. It's best to think carefully before taking action.

☐ 67. On balance I do the listening rather than the talking.

☐ 68. I tend to be tough on people who find it difficult to adopt a logical approach.

☐ 69. Most times I believe the end justifies the means.

☐ 70. I don't mind hurting people's feelings so long as the job gets done.

☐ 71. I find the formality of having specific objectives and plans stifling.

☐ 72. I'm usually one of the people who puts life into a party.

☐ 73. I do whatever is expedient to get the job done.

☐ 74. I quickly get bored with methodical, detailed work.

☐ 75. I am keen on exploring the basic assumptions, principles and theories underpinning things and events.

☐ 76. I'm always interested to find out what people think.

☐ 77. I like meetings to be run on methodical lines, sticking to laid down agenda, etc.

☐ 78. I steer clear of subjective or ambiguous topics.

☐ 79. I enjoy the drama and excitement of a crisis situation.

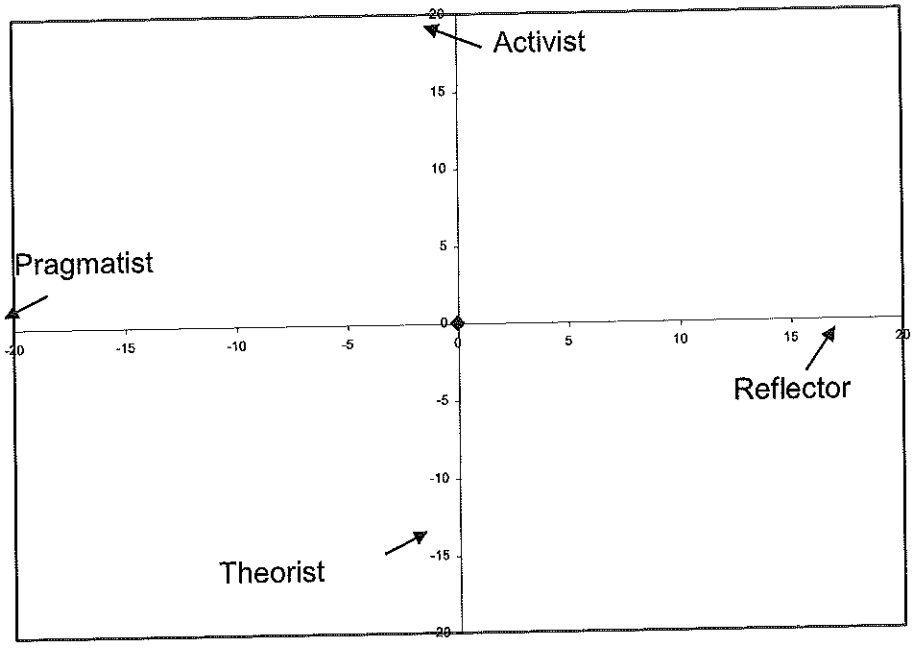
☐ 80. People often find me insensitive to their feelings.

Scoring

You score one point for each item you ticked. There are no points for crossed items. Circle the questions you ticked on the list below:

2	7	1	5
4	13	3	9
6	15	8	11
10	16	12	19
17	25	14	21
23	28	18	27
24	29	20	35
32	31	22	37
34	33	26	44
38	36	30	49
40	39	42	50
43	41	47	53
45	46	51	54
48	52	57	56
58	55	61	59
64	60	63	65
71	62	68	69
72	66	75	70
74	67	77	73
79	76	78	80
Totals			
Activist	Reflector	Theorist	Pragmatist

Plot the scores on the arms of the cross below:



Your result may show that you have a particular learning style. It may be useful to bear this in mind as you approach tasks. Was the approach you adopted the best one in the circumstances? Would adopting another learning style have improved you performance?

At this point you may also find it helpful to read through *Characteristics of the Four Learning Styles*, which follow. This provides more detail and should help you clarify your sense of your own preferred style(s)

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PART TWO

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Notes:

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PART THREE

SMART Goals
Setting up Precepting for Success

Diana Poon, CPNP
Preceptor Workshop 2020 A1

1

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Objectives

- Guides preceptor to meet student's clinical objective A2
- Promote communication between preceptor and student
- Improve understanding of student's clinical ability
- Allows constant and consistent feedback, and encouragement to student as they learn A3

2

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Slide 1

A1 Do we want to date this? Would it be better to leave it dateless so it ages well?
Author, 11/30/2020

Slide 2

A2 Make this "guide" and "allow" to be consistent with other objective tenses
Author, 11/30/2020

A3 Can probably just keep consistent and get rid of constant!
Author, 11/30/2020

SMART Goals

3

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SMART questions

- Specific: What / who exactly is involved?
- Measurable: How will we know if the goal is achieved?
- Attainable: Can it be done in the proposed timeframe?
- Relevant: Do we have resources to achieve this goal?
- Time-Based: When should this goal be achieved?

4

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Types of Goals

- Long-Term:
  - Identifying what the student should learn by the end of the preceptorship
  - *Instead of: I want to be a better provider*
  - SMART goal examples:
    - Over the next 3 months, I will practice performing comprehensive physical examinations, that are age-specific, to identify any concerns.
    - By the end of the preceptorship in 3 months, I will be able to come up with at least 3 differential diagnoses for each patient
    - In 2 months, I will be able to write a comprehensive H&P, by asking pertinent +/-, review of systems, and practicing writing one every week.

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Types of Goals

- Short-Term:
  - Can be the goals for the next week(s), or for the day
  - *Instead of: I want to learn more about the patients*
  - SMART goal examples:
    - For the next two weeks, I will focus on reviewing the labs of one patient, and identifying any abnormal labs, and explain reasons why this may have occurred
    - Today, I will be able to concisely present to my preceptor on 2 patients.
    - By next week, I will be able to write progress notes / clinical notes for 2 patients

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How to Start Goal Setting

- Review school objectives with the student
- Identify if student is in first or second year
- Ask broad questions of what students wants to learn, and help identify SMART goals
- Goals can be used to help develop student in clinical skills, knowledge, and professional growth.

7

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Feedback

- Review goals throughout the preceptorship
- Throughout the preceptorship, identify areas of places to improve, and adjust SMART goals accordingly
- Provide resources and methods to reach the goals
- Encourage and praise student as they achieve goals
- Applaud both student and preceptor (give yourself a pat on the back!) in helping student grow!

8

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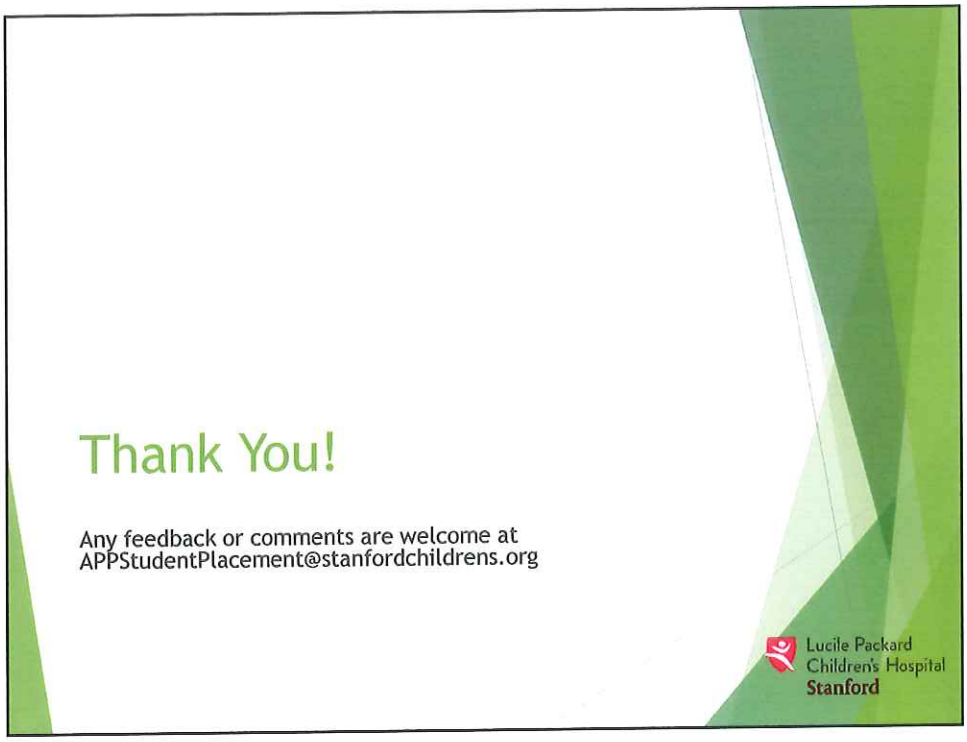
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One Minute Preceptor

Heidi Terwey, PA-C

Lucile Packard Children's Hospital Stanford

What is "One Minute Preceptor?"

- Teaching method used to guide the preceptor/student relationship with the use of 5 easy steps during case presentation.
- Can be used in both inpatient and outpatient settings.
- Designed to give the student increased ownership and level of clinical reasoning during a presentation.
- Gives the preceptor a chance to provide immediate feedback.

#1. Get a commitment.

- Instead of taking the time to present a detailed HPI, have the student tell you right away what they think is going on with the patient.
- "What is your diagnosis?" or "Tell me what you think is going on with this patient."
- Get the student to commit to either a diagnosis or a plan upfront.

#2. Probe for Evidence.

- "What factors in the HPI support your decision?"
- Is the student just *guessing* or is there a reasonable thought process?
- Assess your student's level of competence at this stage.

#3. Positive Reinforcement

- Reinforce with the student what was done well.
- Positive feedback reinforces desired behaviors, knowledge, and enriches the encounter or experience.
- The student may not realize that they did something well if you as a preceptor do not tell them.

#4. Give guidance about errors/omissions

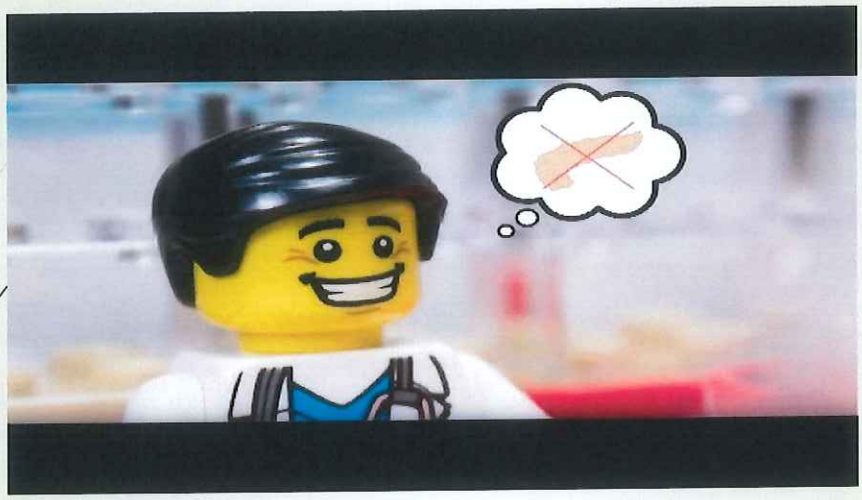
- You cannot improve without feedback.
- Be considerate and respectful.
- Focus on only one or two issues at a time.
- Stay *in the moment*.

#5. Teach a general principle

- Share a pearl of wisdom relevant to the case.
- Have the student write it down, and at the end of the clinic or rotation, they will be happy with everything that they've learned.
- Can be a clinical pearl or small piece of advice.

See it all in action!

(allow 5 minutes for the following YouTube video)



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The Journal for Nurse Practitioners 16 (2020) 466–469

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journal homepage: www.npjournal.org

By Faculty for Faculty

The One-Minute Preceptor: Evaluation of a Clinical Teaching Tool Training for Nurse Practitioner Preceptors

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Keywords:
interprofessional precepting
nurse practitioner education
One-Minute Preceptor
precepting

A B S T R A C T

Health professionals cite a number of barriers to precepting nurse practitioner (NP) students, including lack of time and training. The primary aim of this study was to evaluate training of health professionals who teach NP students in a clinical teaching model, the One-Minute Preceptor (OMP). The OMP is a clinical teaching tool that has the potential to increase feedback to NP learners, improving their perceived clinical experience and learning opportunities. The secondary aim was to evaluate the impact of this training on perceived barriers to clinical teaching. The training included a 2-hour workshop on clinical teaching models within a community setting, with an emphasis on the OMP. The intervention was offered twice and included 57 participants from 4 different health professions. Data were collected before and after the intervention using an online survey. There were no differences between professions in outcomes, including barriers to teaching; however, an increase was found in providing positive and corrective feedback as well as overall teaching activities.

Nurse practitioners (NPs) have the potential to address the anticipated shortage of primary care physicians.[1] Although there are sufficient NP programs throughout the United States, there is currently a shortage of preceptors and quality clinical placement opportunities for students.[2] To overcome this shortage, NP programs depend on preceptors from a variety of health professions, including NPs, certified nurse-midwives, medical doctors, doctors of osteopathy, and physician assistants. However, there is a lack of standardization of preceptor preparations and expectations.[2-4]

There are many barriers to precepting, including lack of training, productivity demands, time burden, and lack of support from educational programs.[5-7] The One-Minute Preceptor (OMP) is a clinical teaching tool developed for medical education in ambulatory care to improve teaching techniques[8,9] It has the potential to increase time efficiency in all clinical teaching sites.[10] This project evaluated a training program focusing on use of the OMP and its effect on perceived barriers of clinical teaching.

Literature Review

Clinical education is a key component of the education of health care professionals.[11] A current shortage of primary care preceptors for NP students across the country impacts the ability to educate NPs and expand the primary care workforce.[12] With the increase in interprofessional health care settings there has also been an increase in interprofessional precepting.[13,14] Research analyzing barriers and incentives to clinical teaching or precepting found similar incentives and barriers across professions. Incentives include professional obligation, contact with faculty or program, and desire to teach.[7,15] Barriers include productivity demands and time burden.[7]

The OMP clinical teaching tool includes 5 microskills: (1) get a commitment, (2) probe for evidence, (3) teach a general rule, (4) reinforce what was done well, and (5) correct mistakes (Table 1).[9] The literature consistently supports the use of OMP as a well-established educational intervention for preceptors, specifically medical educators.[8,9,16,17] The model has been evaluated for effectiveness, including incorporation of techniques into practice, sustainability over time, and quality of teaching. It has also been evaluated for preference over alternate and traditional clinical teaching models.[18]

Studies of the use of the OMP have demonstrated significant improvement in teaching skills as perceived by student and teacher. Students rated the teachers higher in their degree of inclusion of the student in decision making, evaluation of the student's knowledge, and provision of feedback.[19-21] In addition, use of the OMP approach has been shown to increase feedback to students.[10,21,22] Whereas more traditional models of preceptor and preceptee interaction focus on history taking and presentation skills, the OMP has an increased focus on building the student's skills, such as development of a differential diagnosis and a management plan.[10] Use of the OMP model supports the key elements

https://doi.org/10.1016/j.nurpra.2020.03.016

Table 1
The One-Minute Preceptor Model

The One-Minute Preceptor is a clinical teaching model that aims to improve the effectiveness and efficiency of precepting[9]		
Five Steps	Description	Example
Step 1: Get a commitment	The preceptor gets a commitment from the students. This commitment can vary based on the learner level. For example, a preceptor may ask an advanced student to commit to a diagnosis or a management plan, whereas an early learner may be asked to commit to which physical examination components to complete based on the chief complaint or presentation.	*"What do you think is the most likely diagnosis is for the patient's persistent cough?"*
Step 2: Probe for evidence	The preceptor asks a follow-up question to elicit the student's clinical reasoning. This step can provide additional information on how the student came to their conclusion. It allows the preceptor to tailor future teaching.	*"Did you consider any nonpulmonary diagnosis in your differential for the cough?"*
Step 3: Teach a general rule	The preceptor provides additional knowledge and skills to the student. This can be evidence based or based on clinical expertise.	*"There are many nonpulmonary etiologies that can present with a cough. For example, gastroesophageal reflux disease can also present with an intermittent persistent cough."*
Step 4: Reinforce what was done well	The preceptor identifies specific behaviors that the student did well. These are actions that the preceptor expects the student to continue to do.	*"You did a great job of getting a history that included all of the pertinent positives and negatives to develop your differential diagnosis."*
Step 5: Correct mistakes	Lastly, the preceptor corrects mistakes. In addition, the preceptor should provide a rationale for why this behavior/decision is incorrect.	*"In this case a chest x-ray is not indicated. We want to make sure to only order diagnostic imaging and laboratory studies when they are necessary to identifying a diagnosis or developing a management plan."*

of successful precepting, including the development of the student's clinical reasoning,[23] and has been shown to increase time efficiency of precepting a student.[17,24]

The aim of this project was to evaluate an approach to train preceptors from multiple disciplines in the use of the OMP model.

Methods

A 2-hour in-person workshop, "Time Efficient Clinical Teaching," (Appendix A) was implemented in collaboration with an academic institution and a network of community clinics. The academic institution provided workshop faculty, materials, and continuing medical education credits to participants. The community clinic network recruited interprofessional community clinicians who precept NP students to participate in the workshops and hosted the workshops at their site.

Workshop objectives were that participants would be able to (1) describe the basic components of 3 evidence-based clinical teaching models, (2) apply these teaching models in their own clinical setting, and (3) set personal goals for applying the skills learned in the workshop to their own practice setting. The workshop included lecture, videos, participant polls, and skills applications through role play.

The workshop included a brief overview of other tools for clinical teaching, including the RIME (Reporter, Interpreter, Manager, Educator) framework,[25] a tool for identifying and monitoring student progress, and SNAPPS (Summarize, Narrow, Analyze, Probe, Plan, Select), a learner-driven clinical teaching model,[26] but most of the time was spent on the OMP. During the OMP section of the program, participants learned about the model, watched a video demonstrating its use, and practiced applying the model in small-group role plays. Outcome evaluation focused on use of the OMP teaching model.

Setting, Participants, and Design

The intervention was presented twice, each at a location centrally located for clinicians in the network. Both were facilitated by the same educators. Registration was online and included name, profession, email, and organization. The only criterion for attendance was being a community clinician who practiced in outpatient settings such as primary care. There were no limitations regarding prior teaching of students or prior training on clinical teaching to restrictions on the number of years of practice. The program was available to all clinicians, including but not limited to NPs, doctors of medicine (MDs), physician assistants (PAs), and doctors of osteopathy (DOs). The workshop was evaluated using a pre-post intervention design.

Measurement

Data were collected via Qualtrics, an online survey platform. Overall quality of the session and likelihood attendees will change their teaching or professional practices as a result of the session were evaluated via a 5-point Likert scale. Clinicians were asked to indicate barriers to precepting a student at their practice via a list of common barriers using a 7-point Likert scale between strongly disagree (1) to strongly agree (7). Barriers included time burden, productivity demands, lack of administrative support, lack of teaching training, insufficient program support, and lack of space. Clinician use of the 5 microskills of the OMP was evaluated via "Use of the Teaching Skills," a validated 14-question survey which evaluates use of the 5 OMP microskills (commit, probe, "pearls," feedback, and overall). Clinicians were asked how frequently they use each of the skills via a 7-point Likert scale between never (1) and every time (7).

Registered participants received an email with a link to the preprogram survey 24 hours before the session. An opportunity to complete the survey was also provided upon arrival to the training session. After completion of the training session, clinicians were encouraged to immediately complete the postsurvey using a provided link. Clinicians also received an email 24 hours and 1 week after the session with a reminder to complete the postsurvey. An anonymous 4-digit number was used on all surveys to prevent duplication. Data were analyzed using IBM SPSS 24 software (IBM Corp). The collected data were analyzed by a Mann-Whitney *U* test with a significance of $P < .05$. Both sessions were analyzed individually and then as a whole to identify any variance.

Ethical Considerations

This project was approved by the University of California, San Francisco, Internal Review Board. Participants were informed of the

Table 2
Reported Use of the One-Minute Preceptor

Domain	Content	Presession	Postsession
		Median (range)	
Step 1: Get a commitment	• Ask for the student's diagnosis • Involve the student in decision making	5.5 (3-7)	5.5 (1-7)
Step 2: Probe	• Ask for their reasoning • Evaluate the student's knowledge	5.0 (2-6.5)	5.5 (1-7)
Step 3: Teach a general rule	• Teach a general rule	5 (2-7)	6 (1-7)
Step 4 & 5: Positive and corrective feedback	• Give positive feedback • Explain why it is correct • Offer suggestions for improvement • Provide feedback frequently	5 (3-7)	6[a] (1-7)
Overall teaching	• Motivate the student to do outside learning • Overall teaching effectiveness	4.5 (1-6.5)	6[a] (1-6.5)

[a] $P < .05$ (statistically significant).

use of the results of the surveys and opted in to participate. Participation in the survey was not a requirement to attend the workshop.

Findings

In the first session, there were 24 participants from 4 professions (NPs, MDs, DOs, and a doctor of psychology). In the second session, there were 33 participants from 2 professions (NPs and MDs). The presurvey was completed by 36 participants, a 63% response rate, and 27 participants completed the postsurvey, a 47% response rate. Incomplete surveys were not included in the data analysis. Of the participants who responded, 85% stated that they were currently involved in clinical teaching at their clinical site. There was no difference in responses between health professions to any of the survey items. There was no significant difference in their use of the OMP or in their perception of barriers to precepting.

When compared with preprogram data, there was a statistically significant increase in intended use of steps 4 (reinforce what was done well) and 5 (correct mistakes) ($U = 308.5$, $P < .05$). A significant increase was also noted in overall teaching ($U = 309.5$, $P < .05$) in the OMP approach. For one of the sessions, there was also a significant increase in step 2 (probe for evidence) ($U = 89.5$, $P < .05$; Table 2).

All listed barriers to precepting students were rated low by participants. There was no significant change in reports of perceived time burden, productivity, lack of administrative support, lack of teaching training, or insufficient support between presession and postsession evaluations. However, there was a significant increase in the perception of lack of space as a barrier to teaching on postsession evaluations ($U = 346.5$, $P < .05$; Table 3).

Participants rated the overall satisfaction of the session on a scale of poor (1) to excellent (5). The overall quality of the sessions was rated 4.74 and 4.14. Respondents rated high the likelihood that they would make changes in their teaching or professional practices as a result of the sessions, with mean scores of 4.5 and 4.31 in the 2 sessions.

Discussion

This study sought to determine response to education of preceptors in use of the OMP clinical teaching model by community clinicians from multiple professions who teach NP students. Self-reported use of the 5 OMP microskills preintervention and postintervention and whether there was an impact on the barriers to precepting were also examined. Consistent with previous studies by Salerno et al,[21] Eckstrom et al,[27] and Teherani et al,[18] training in the OMP model led to increased self-reported incorporation of use of some of the microskills in clinical teaching. This is in contrast to the study by Ong et al[28] that found no change in clinical teaching. In the study by Salerno et al,[21] training led to incorporation of all 5 microskills, whereas we found a statistically significant increase in reported use of only 2 of the 5 microskills. The study by Eckstrom et al[27] saw an increase in steps 1 (get a commitment), 2 (probe for evidence), and 4 (give positive reinforcement), whereas we found an increase in intent to do steps 4 (give positive reinforcement) and 5 (correct mistakes).

The increase in feedback in steps 4 and 5 of the OMP is consistent with the literature. Arya et al,[22] Eckstrom et al,[27] Furney et al,[20] Ignoffo et al,[10] and Salerno et al[21] all demonstrated increased feedback to learners as a result of the OMP. This is important, because nursing students perceive feedback as an important attribute of an educator and of a good clinical experience.[29]

Training community clinicians in use of the OMP model did not decrease the perceived time burden of clinical teaching, which to our knowledge has not previously been evaluated in the literature. These results could be due to the high number of participants already teaching in the clinical setting, since they may have already overcome these barriers.

This intervention demonstrates that training in the OMP is well-received across health professionals who teach NP students. It also demonstrated no difference in use of the OMP model by different health professionals. This may be due to the similar roles that MDs and NPs maintain in community clinics.[30] This interprofessional model of training community clinicians in clinical teaching has the potential to support the interprofessional clinic models that are expanding to meet health care demands.

Limitations

Outcomes are limited to self-report at the time of or shortly after the intervention. We did not measure actual use of the OMP in the clinical setting. The findings may not be generalizable to inpatient or other clinical settings where the role of varied providers may be significantly different.

Table 3
Barriers to Clinical Teaching

Barrier to Clinical Teaching	Presession	Postsession
	Median (Range)	
Time burden of teaching	6 (2-7)	6 (4-7)
Productivity demands	6 (1-7)	6 (2-7)
Lack of administrative support	4.5 (1-7)	4 (1-7)
Lack of teaching training	5 (2-7)	4 (1-7)
Insufficient program support	5 (1-7)	4 (2-6)
Lack of space	4 (1-7)	5 (2-6)[a]

[a] $P < .05$ (statistically significant)

Participants in the intervention also self-selected to participate. This may indicate they value clinical teaching training and the OMP intervention more than those who did not choose to attend.

The sample size is also a limitation. With a larger sample, we might see statistical significance in use of the other microskills of the OMP. In addition, only 51% of participants completed both the pre and post surveys. Although this number is high for survey response, it may impact the findings.

Lastly, the data were collected over a short time period and were not based on actual observation of use of the OMP approach. Long-term data and information may provide a broader perspective of the potential impact of the OMP on clinical education.

Conclusion

The OMP model is a clinical teaching tool that can be taught to community clinicians who teach NP students. Although there was not a reported increase in use of all 5 of the steps, this was not directly observed. Feedback is one area that students consistently want more of, and this tool may therefore help improve students' perceptions of their clinical experiences. Standardization of preceptor training to include the OMP could enhance NP student clinical education. Future studies could evaluate actual behavior change of preceptors and student perception of teaching skills post OMP training.

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Appendix A
Intervention

Time	Activity	Active Engagement Strategy
10 min	Preworkshop survey	Qualtrics link
10 min	Introduction	Go around with participants, state their profession and what they want to get out of this day, write themes on board
5 min	Background—review challenges in clinical teaching	Ask participants about challenges
5 min	Observer-Reporter-Interpreter-Manager-Educator (O-RIME)	Have participants describe times they have switched from manager to reporter; or other switches
10 min	Summarize, Narrow, Analyze, Probe, Plan, Select (SNAPPS)	Overview Evidence –brief literature review Video
10 min	One-Minute Preceptor (OMP)	Overview Microsteps 1, 2, and 3
10 min	OMP	Microsteps 4, 5, and 6 Literature
25 min	OMP	Video Evidence Small groups/practice
15 min	Feedback—overview of best practices	Participants think of when they received feedback in an effective manner Poll
5 min	Summary	
5 min	Evaluations	Give time to complete
10 min	Complete postintervention survey	Qualtrics link
Total 120 minutes		

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PART FOUR

Define Your Specialty

How to choose 5 top diagnoses for your clinical area and help your student stay focused on their objectives-

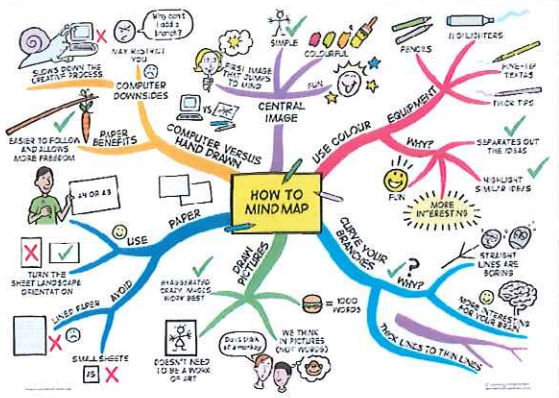
By Heidi Terwey, PA-C

Lucile Packard Children's Hospital Stanford

I want to take on a student, but I'm not sure what or how I can teach them…

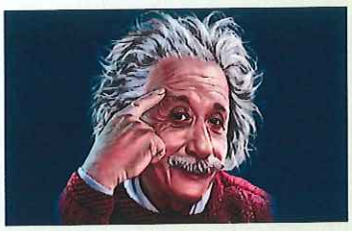
- Often, we are intimidated by taking on students ourselves because we are afraid that we have little to offer.
- We are so specialized, we wonder how we can provide relevant material to a student in the midst of their education.
- We are super-busy and do not have a lot of time available to develop a comprehensive curricula… OR DO WE??

Break it down!



5 Simple Steps to Creating an Amazing Rotation…

- 1. Pick your top 5 diagnoses in your clinical practice:
  - Look at your clinic schedule/or if you are inpatient, your list of patients assigned to your team.
  - Your day to day patients…who do you see?
  - Your 5 most basic procedures in your practice. What are they?
  - Brainstorm with your team.



5 Simple Steps to Creating an Amazing Rotation…

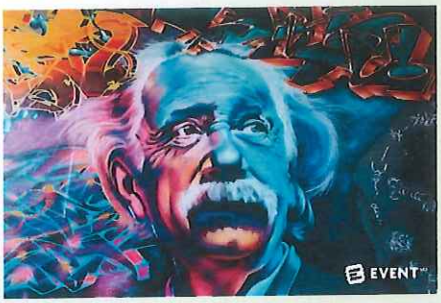
- 2. Choose how your student will observe your "top 5"-
  - Through doing a detailed History and Physical
  - Observing Procedures (for instance, ASD closure for ASD)
  - Evaluating as an inpatient
  - Online resources
  - Other

5 Simple Steps to Creating an Amazing Rotation…

- 3. Choose how your student will demonstrate understanding of core principles-
  - Can s/he explain clinical presentation and history findings?
  - Describe unique characteristics of the particular diagnosis?
  - Discuss appropriate Imaging modalities?
  - Employ the importance of key physical exam findings?
  - Identify other associated syndromes/defects (ie-genetics)?
  - Identify proper treatment?

5 Simple Steps to Creating an Amazing Rotation…

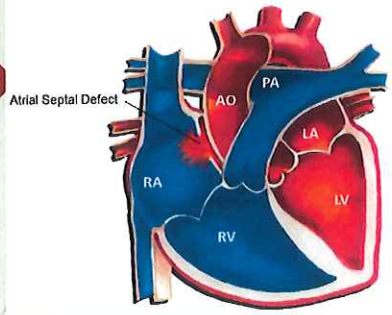
- 4. Leave room for comments
  - Give space for free thought
  - Key phrases/mnemonics that are relevant



5 Simple Steps to Creating an Amazing Rotation…

- 5. Make a Handout for each one
  - Include a photo of your diagnosis or a helpful diagram
  - Create a table for your observation(s) for the student to keep track of
  - Create another table for core principles
  - Add a section for comments

Examples

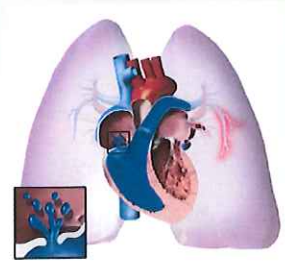


Atrial Septal Defect "ASD"

OBSERVATION:	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	√
Explain clinical presentation and history findings:	
Delineate the different types of ASDs:	
Appropriate imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:



Pulmonary Hypertension

OBSERVATION:	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	√
Explain clinical presentation and history findings:	
Delineate the different types of Pulmonary Hypertension:	
Appropriate imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

Plagiocephaly			
OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Plagiocephaly	
Appropriate imaging modalities:	
Employ the importance of physical exam findings:	
Proper treatment plan identified:	

COMMENTS:

Myelomengiocele			
OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physcal:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Myelomengiocele:	
Appropriate imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

Templates

OBSERVATION:

	Date #1:	Date #2:	Date #3:
History and Physical:			
***:			

VERBAL ASSESSMENT:

	√
Explain clinical presentation and history findings:	
Delineate the different types of ***:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

Thank You!

Any feedback or comments are welcome at
APPStudentPlacement@stanfordchildrens.org

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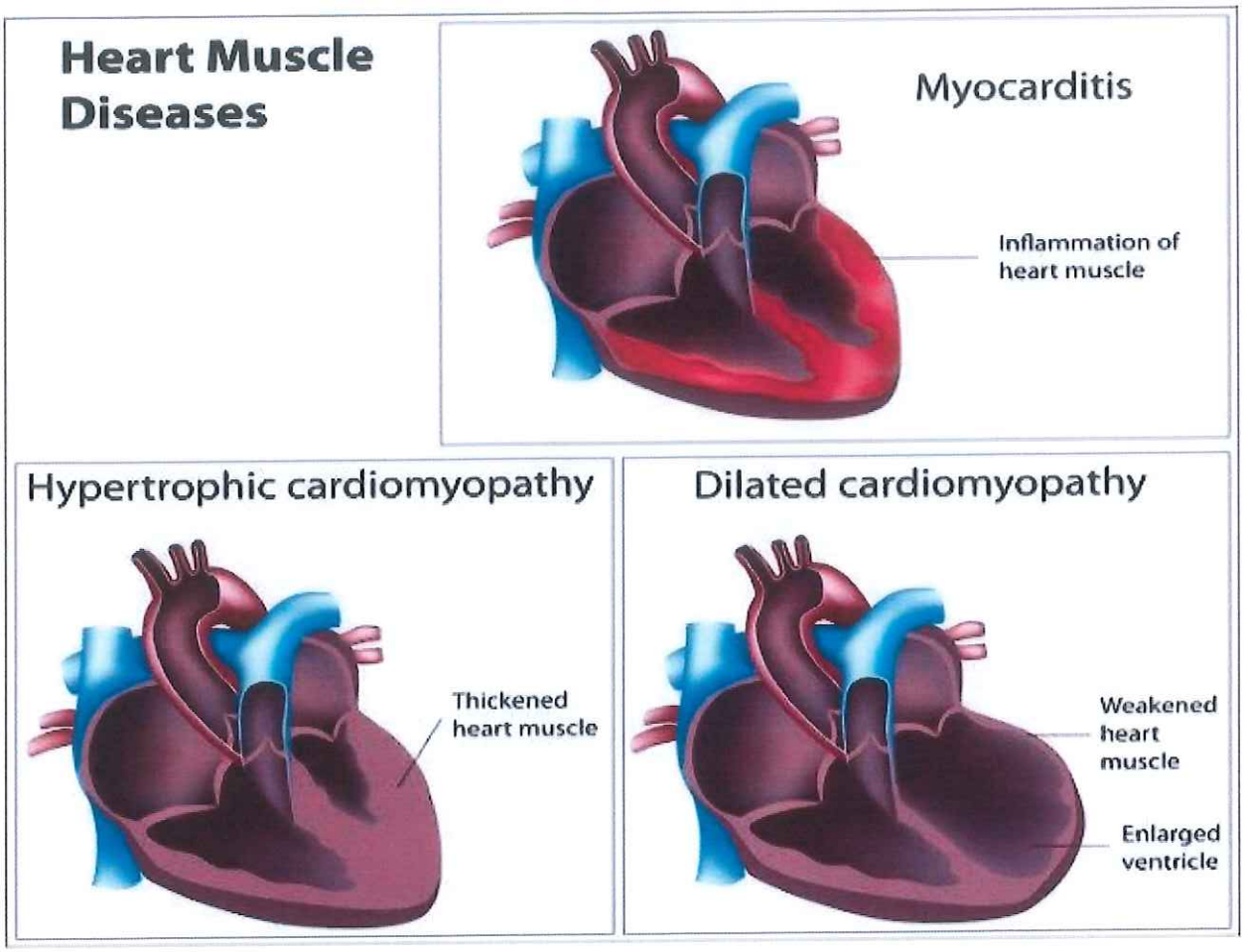
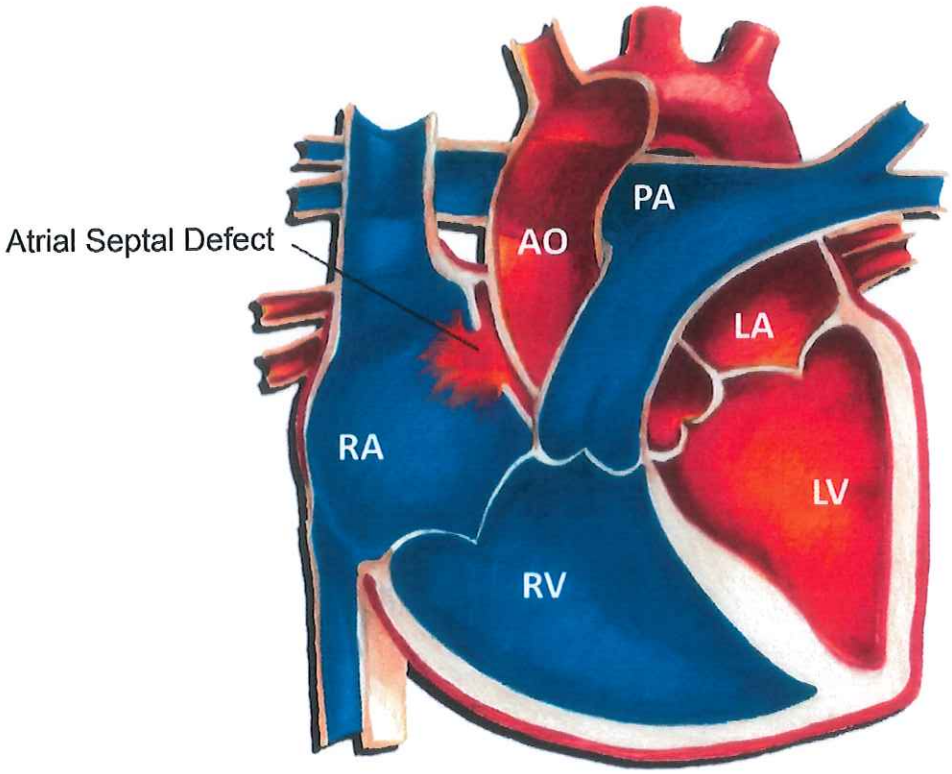


Cardiomyopathy/Transplant/Cardiac Biopsy

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of ASDs:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

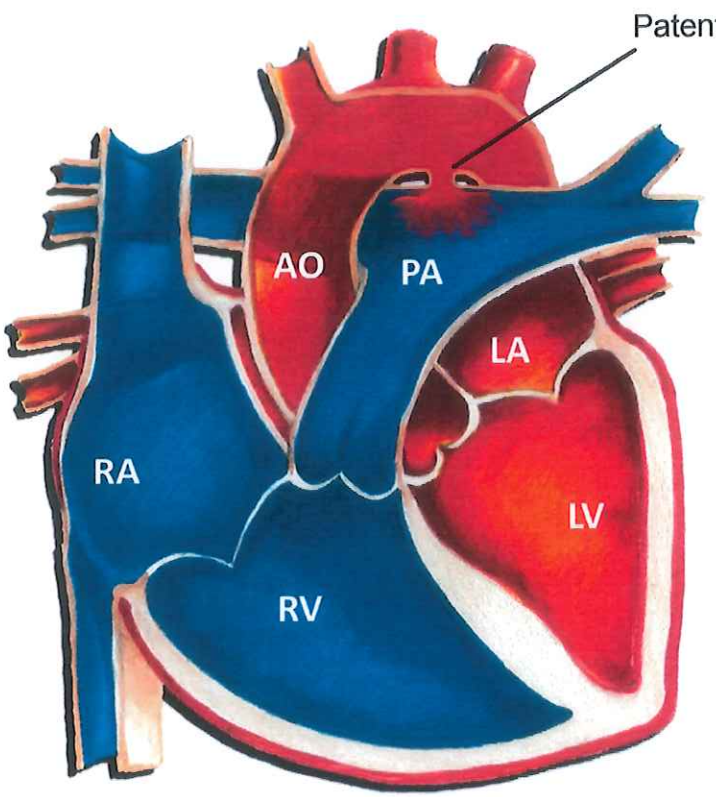


Atrial Septal Defect "ASD"

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of ASDs:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

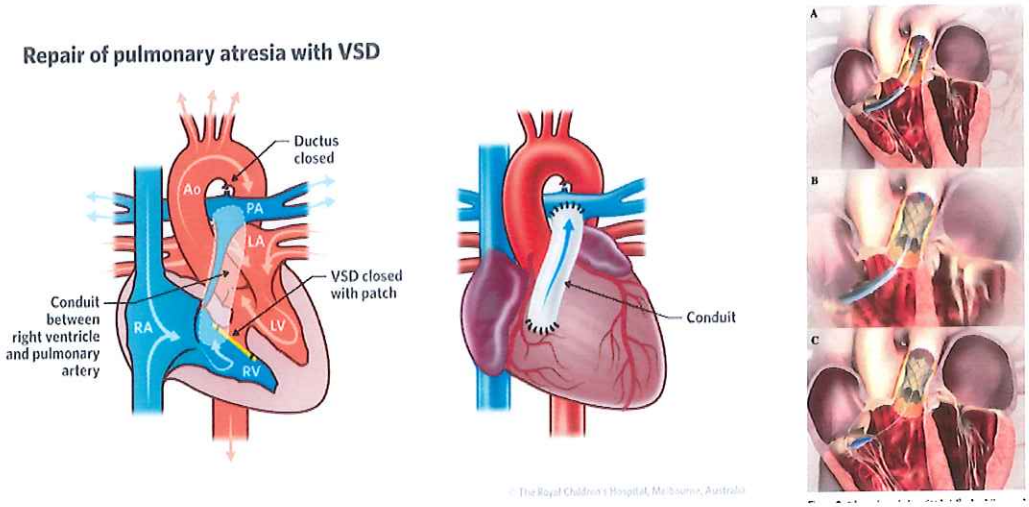


Patent Ductus Arteriosis "PDA"

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of PDAs:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:



Pulmonary Atresia/VSD (TOF) with MAPCAs

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			
Cardiac Catheterization:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Repairs:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

Lucile Packard APP Student Rotation Guide

Pediatric Neurosurgery

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2. Camille Bloom, PA-C (415) 525-9308 (San Francisco)
3. May Casazza, PNP (650) 862-7396
4. Stephanie Choi, PNP (650) 206-0063
5. Diana Poon, PNP (650)- 862-8196
6. Camly Slawson, PNP (415) 321-9667 (Walnut Creek)
7. Sarah Tanquary, PA-C (925) 393-8212
8. Danielle Gomez Jimenez, PNP

Resources:

1. Web Resources: CHOP Open Access: https://www.chop.edu/centers-programs/chop-open-access-medical-education
2. Textbooks:
    a. Principles and Practice of Pediatric Neurosurgery 3rd edition, 2014
    b. Pediatric Neurosurgery (Neurosurgery by Example) 2019
    c. Fetal and Neonatal Neurology and Neurosurgery, 3rd Edition
    d. Diagnostic Imaging: Pediatric Neuroradiology

Technical Skills:
During this rotation you will observe APPs performing certain technical skills. It is possible that some of these skills are in the realm of the student, while others require specific licensure and credentialing to perform by a practicing APP.
The following are some skills for a practicing APP, though not all APPs in the practice group will perform these:

1. Shunt reprogramming
2. Shunt tap
3. Suture removal
4. EVD management
5. Lumbar Puncture
6. Surgical First/Second Assist

Imaging:
As an APP in neurosurgery, understanding of imaging and how to interpret is a key component of your knowledge and competency. During your rotation, take the time to test your knowledge, ask questions, and learn more:
The following are the imaging most often used in neurosurgery:

1. MRI with and MRI without contrast of the brain and spine
2. MRA and MRV
3. CT of the head and spine
4. Ultrasound of the head and spine
5. X-ray of the spine and skull

Diagnoses:

Every practice area has a list of common diagnoses. As a student it is best to familiarize yourself with the most common diagnoses. The following is a list of common diagnoses that you should see during your rotation. If you don't see every diagnosis, take the time to learn about them from the resources provided.

Skull Diagnoses
Plagiocephaly
Craniosynostosis
Dermoid Cyst

Brain Diagnoses: CSF Flow Dynamics
Hydrocephalus (communicating)
Hydrocephalus (obstructive)
Pseudo Tumor Cerebri

Brain Diagnoses: Anatomical
Chiari Malformation
Arachnoid Cyst

Brain Diagnoses: Pathological
Supratentorial Brain Tumors
Infratentorial Brain Tumors
Brain stem tumors
Brain abscess

Brain: Vascular Disorders
Cavernous Malformation
Arteriovenous Malformation
Moya Moya Disease

Trauma
Cervical Spine Fracture

Epidural Hematoma
Subdural Hematoma
Skull Fracture
Concussion
Traumatic Brain Injury

Congenital Spine
Myelomengiocele
Tethered Cord
Scoliosis

Surgical Epilepsy
Vagal Nerve Stimulator
Depth Electrode and Resection Surgery

Other
Surgical Spasticity- Baclofen Pumps

Clinical Competency:

Every APP student should have some experience independently seeing patients- taking a history and physical and presenting the patient to a preceptor. To guide your learning, you will be expected to see the following **five** common diagnoses and receive feedback on your knowledge, clinical skills, and plan for that patient

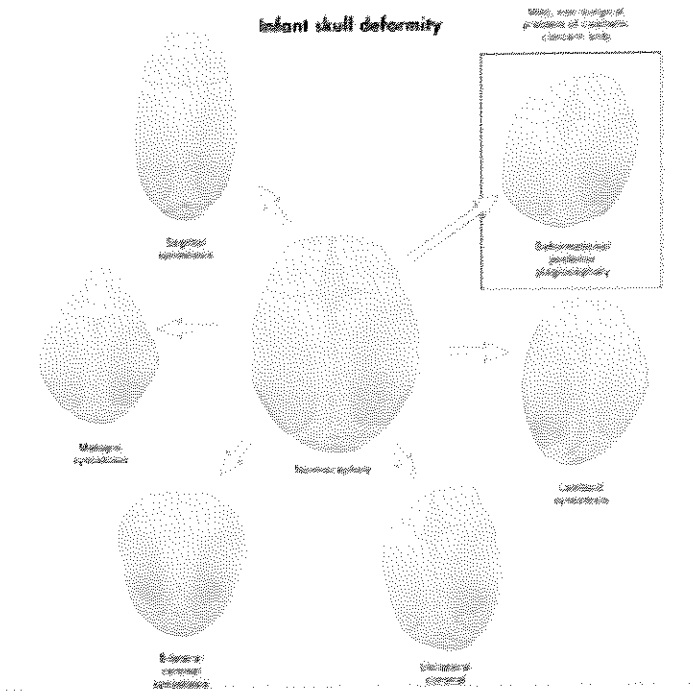
Initially observe your preceptor seeing these diagnoses prior to seeing the patient independently.

Plagiocephaly

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Plagiocephaly	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Proper treatment plan identified:	

COMMENTS:

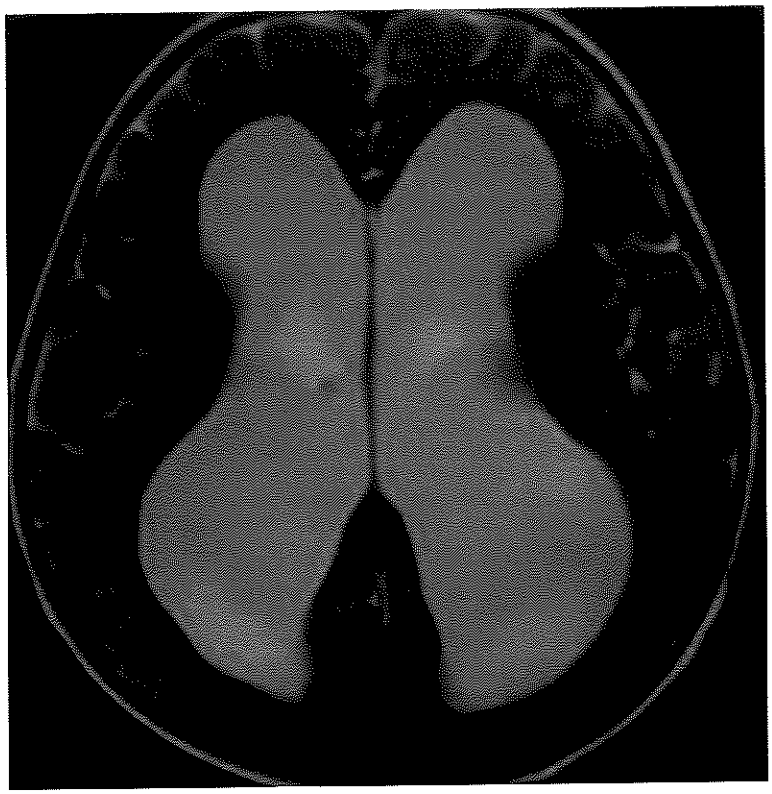


Craniosynostosis

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of craniosynostosis:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

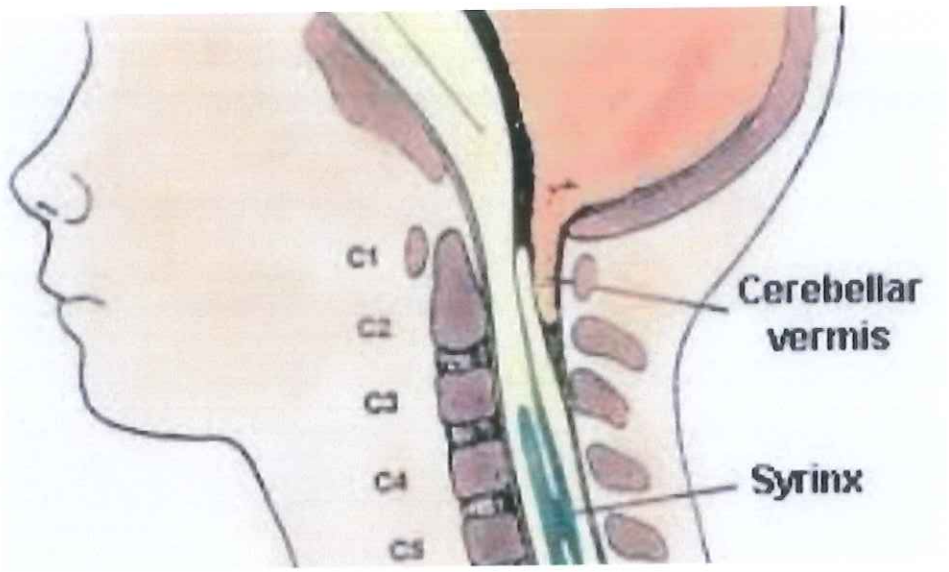


Hydrocephalus (either communicating or obstructive)

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Hydrocephalus:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

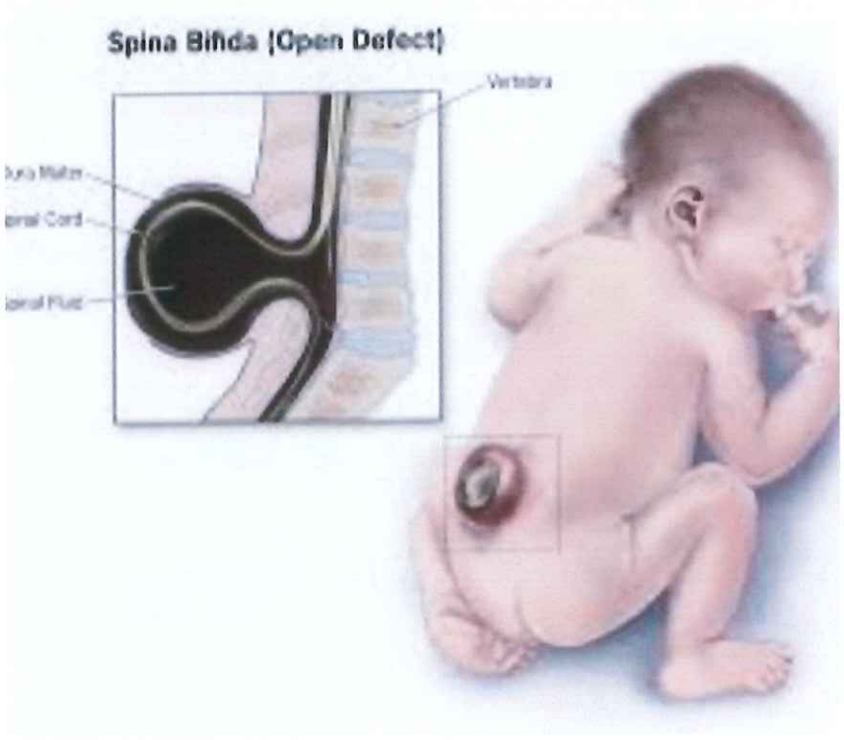


Chiari 1 Malformation

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Chiari 1 malformations:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:



Myelomengiocele

OBSERVATION:			
	Date #1:	Date #2:	Date #3:
History and Physical:			

VERBAL ASSESSMENT:	
	√
Explain clinical presentation and history findings:	
Delineate the different types of Myelomengioceles:	
Appropriate Imaging modalities:	
Employ the importance of physical exam findings:	
Identify associated genetic syndromes:	
Proper treatment plan identified:	

COMMENTS:

Clinical Notes:

During your rotation we would like you to try writing different types of notes. These are examples of APP notes for neurosurgery. These are models of note-writing. Continue to improve your skills through practice and obtain feedback when able.

Outpatient Visit Note:

Dear Provider ***,

Chief Complaint: Subdural Hematoma, right parietal hematoma

Today *** was seen at the Stanford Children's Pediatric Neurosurgery Clinic in *** for evaluation of subdural hematomas, spine hematoma, and hemophilia A. *** presents today with mother, from whom additional history was obtained.

As you will recall, ** is a very pleasant 5-week old male with a history of Hemophilia A (Factor VIII Deficiency), subdural hematomas, parietal hematoma, neonatal seizures, and lumbar spine hematoma. ** was born at 40 weeks gestation and shortly after birth had abnormal events concerning for seizures. He was transferred to Sutter VNC and subsequently to LPCH due to concerns for progression of subdural hematoma as well as a discovered spine hematoma in the L2 region after a lumbar puncture. When he arrived at LPCH he underwent extensive testing due to abnormal coagulopathy concerning for possible hemophilia. His PTT corrected after the administration of factor VIII, therefore he was confirmed to most likely have Factor VIII. ** spent a week in the hospital stabilizing, receiving a port, and learning to feed.

He has been doing well at home. Mom reports no seizure events. He has had occasional shivering episodes, and some jerking of the extremities when falling asleep. He has been doing some physical therapy and Mom does note that he has a preference to look to the right side. He has had no episodes of nausea, vomiting, lethargy or changes in mental status.

Medications:

Current Outpatient Medications

Medication	Sig	Dispense	Refill
• ferrous sulfate (FER-IN-SOL) 15 mg/mL drops	Take 0.9 mLs by mouth daily.		
• ferrous sulfate (FER-IN-SOL) 15 mg/mL drops	Take 0.9 mLs (13.5 mg of iron total) by mouth daily.	50 mL	3
• heparin, porcine, PF, 10 unit/mL Syringe	Inject 1 mL (10 Units total) into the vein as needed.	30 mL	0
• NF-UNLISTED MED • pediatric multivitamin drop (POLY-VI-SOL) YES Drops solution	Take 1 mL by mouth daily.	50 mL	3
• PHENobarbitaL 4 mg/mL elixir	Take 2.5 mLs by mouth 2 (two) times a day.		

• PHENobarbitaL 4 mg/mL elixir	Take 2.5 mLs (10 mg total) by mouth 2 (two) times a day.	200 mL	0
• levETIRAcetam (KEPPRA) 100 mg/mL solution	Take 1.5 mLs (150 mg total) by mouth 2 (two) times a day.	90 mL	5
• pediatric multivitamin chewable tablet	Take 1 mL by mouth daily.		

No current facility-administered medications for this visit.

Allergies: No Known Allergies

Past History:
Birth History: 40 weeks gestation, born at Sutter Santa Rosa and transferred to Sutter VNC due to concerns for seizures. Head Ultrasound was concerning for bleeding and an MRI of the spine showed a hematoma after spinal tap. The baby was transferred to LPCH for further management.

Past Medical History:
1. Hemophilia A (Factor VIII)
2. Subdural, right parietal, and spine hemorrhage
3. Neonatal Seizures
4.Torticollis and left-sided neglect

Past Surgical History:
1. Port placement for factor infusions.

Family History:
There is no history of bleeding disorders in the family
There is otherwise no family history of developmental delay, seizures or other neurologic disorders.

Social History: This is the first child of the family. They live in **, CA.

Developmental History:

Review of Systems:

General:negative
Psychological:negative

Ophthalmic:negative
ENT:negative

Allergy and Immunology:negative
Hematologic/Lymphatic:+ Hemophilia A
Endocrine:negative
Respiratory:negative
Cardiovascular:negative
Gastrointestinal:negative
Urinary:negative

Musculoskeletal: negative
Neurological: + seizures, + subdural hematoma and parietal hematoma
Dermatological: negative

Physical Examination:
Head Cir (cm): 39.3 cm (15.47") | Weight: **(!) 5.66 kg** | Length: 61 cm (2' 0.02")

Vitals:

	10/01/20 1055
BP:	94/52
Pulse:	**(!) 179**

General: alert, awake, no acute distress.

HEENT: Anterior fontanelle is flat and sunken, nares patent, MMM
Neck: Supple, some mild tightness in the right sternocleidomastoid, no LAD

Back: back straight, no defects
Chest/Breast Port in chest is clean and well-secured
Lungs: Clear to auscultation bilaterally
Heart: RRR no m/g/r
Abdomen: soft, non-tender, non-distended
Extremities Warm and well perfused
Skin/Hair/Nails: No rashes or neurocutaneous stigmata

Neurologic Exam:
Mental Status: awake and alert, making a few sounds
Cranial Nerves: II-XII intact. There is a strong tendency to look to the right with left-sided neglect. PERRL, EOMI, no visual field deficits, facial sensation intact, expressions symmetric, palate elevation and tongue protrusion midline, hearing grossly intact, and head held in the midline position.
Motor: normal muscle bulk and tone with intact strength in all extremities.
Sensation: intact to LT
Reflexes: 2+ biceps, brachioradialis, triceps, patella and achilles. Toes downgoing.
Coordination: lifting head up in tummy time
Gait: NA
Movement Disorders Exam: NA

IMAGING:

MRI Brain without Contrast
IMPRESSION:

Hemosiderin lined cystic (evolving) hematoma at the right parietal convexity measures about 9 x 14 mm, slightly smaller.
Mild impression on the adjacent gyri.

Otherwise the previously seen subdurals are no longer identified.

Bilateral hemosiderosis (the sequela of prior subarachnoid hemorrhage).

No hydrocephalus.

Signed by: Amy Ho Huang, MD 9/30/2020 12:42 PM
California Pacific Medical Center
(415) 600-3232

Other Result Information

This result has an attachment that is not available.

Result Narrative

MR brain limited hydrocephalus protocol

AGE: 39 days
GENDER: Male
HISTORY: Nontraumatic subdural hemorrhage, unspecified (CMS/HCC);brain and spine hemorrhage

COMPARISON: 8/30/2020

TECHNIQUE: Screening sagittal, axial, and coronal SS FSE T2 sequences only.

Exam performed within 24 hours of patient arrival to the hospital.

FINDINGS:
Limited screening fast imaging protocol obtained.

Interval evolution of the previously seen bilateral subdural hematomas and subarachnoid hemorrhage.

Hemosiderin lined cystic (evolving) hematoma at the right parietal convexity measures about 9 x 14 mm, slightly smaller. It mildly impresses on the adjacent gyri.

No midline shift or new hemorrhage. Mild bilateral hemosiderosis.

No hydrocephalus.

ASSESSMENT:
*** is a 5-week old male with a history of hemophilia A with subdural hematomas, right parietal hematoma, spine hematoma and seizures. He currently has a port and is receiving daily Factor VII infusions. He is stable on phenobarbital and Keppra with no break through seizures, and will be weaning his phenobarbital over the next month. He continues to make daily developmental gains. On exam there is significant left-sided neglect likely due to his right parietal injury and

some compensatory right torticollis. The MRI of the brain is stable with resolution of the subdural hematomas with stable right parietal hematoma. There is no recent spine imaging.

** is currently stable and showing good healing on his MRI. We will continue to follow the hematomas with serial imaging until fully resolved.

PLAN:
1. Return in 2 months with Brain MRI and Fast spine MRI under anesthesia.
2. Continue to follow with neurology concerning seizure medications
3. Contact neurosurgery if any changes in mental status, nausea, vomiting, or lethargy.

Thank you for allowing us to participate in the care of your patient. Please do not hesitate to contact me for any questions or concerns at 1-844-733-2762

I personally spent a total of 35 minutes (V) face-to-face time with the patient, 30 minutes (C) of which were spent on counseling and/or coordination of care of subdural hematomas, spine hematoma, parietal hematoma, and Hemophilia A.

Sincerely,

Pediatric Neurosurgery
Stanford Children's Healthcare

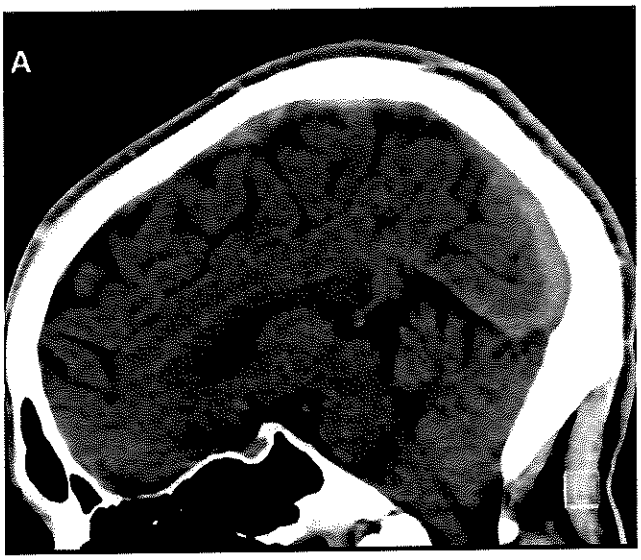
Pre-Surgical H&P

Inpatient Hospital Consult

Case Studies:

1. You are seeing a 12-year-old female with a history of headaches over the past 2 years. She describes them in the frontal region, with some occipital involvement. She denies vomiting, photophobia, phonophobia, or laterality of the headaches. She ocasionaly will notice an increase in pain with coughing or sneezing. She recently had a head injury concerning for a concussion and had a CT of the head performed. The CT was concerning for an abnormality in the posterior fossa.

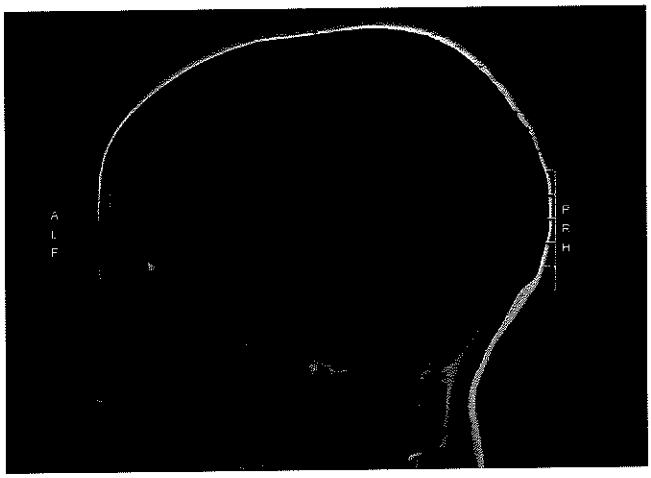
How would you describe this CT scan?



What components of the physical exam would you perform?

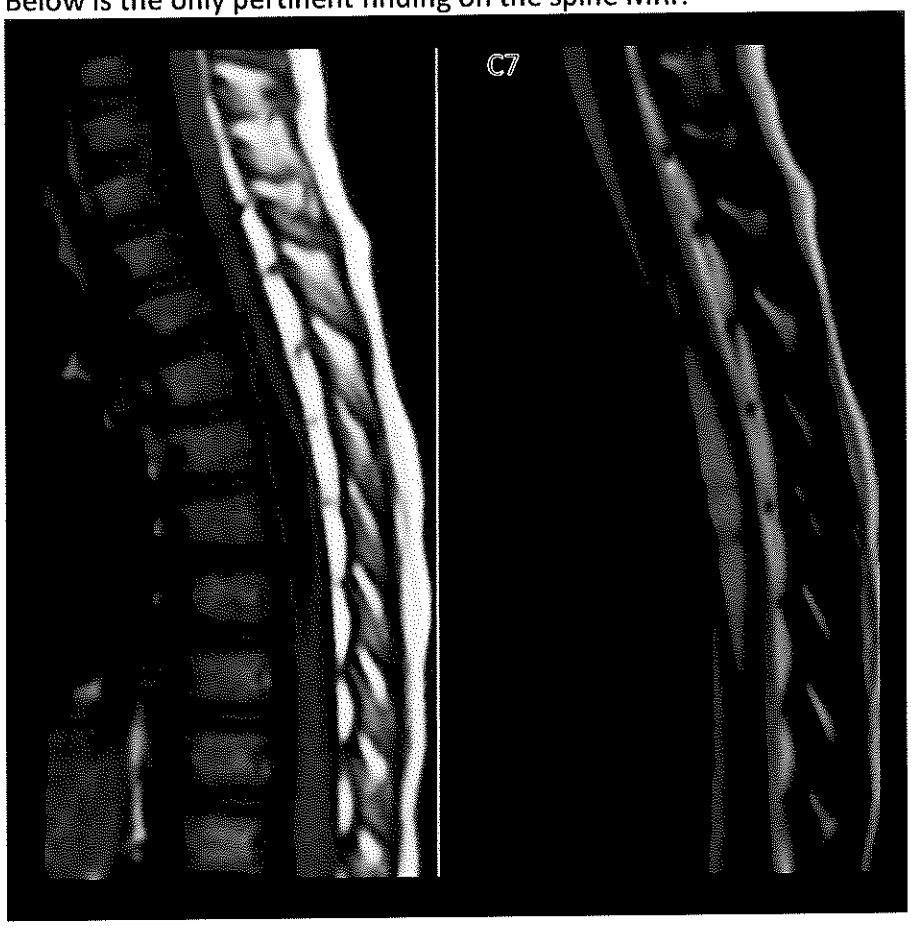
What are your next steps?

The imaging results return:



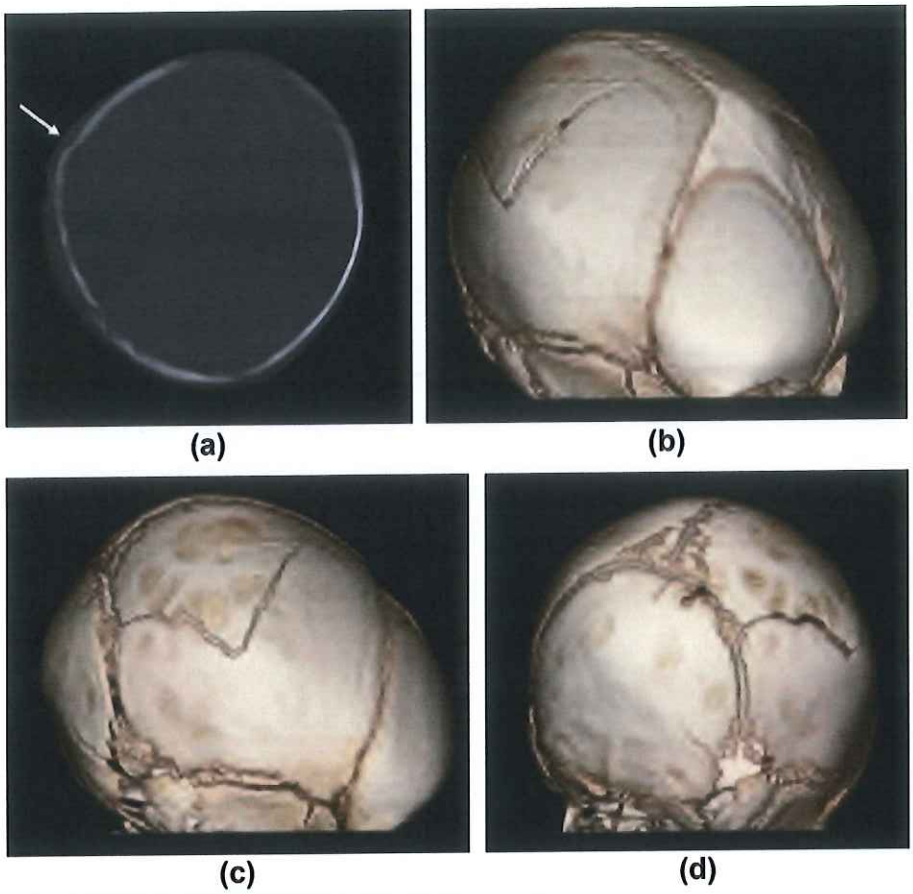
How do you interpret the Brain MRI results?

Below is the only pertinent finding on the spine MRI?



What would be your recommended treatment plan?
Any other recommendations?

2. You are on inpatient rounds and asked to consult on a 3-month-old baby with the finding of a skull fracture after a minor head injury. The baby had been placed on a queen-sized bed. When Mom had gotten up to use the restroom, she had heard a loud thud from the bedroom. She hurried back to find that the baby was face down on the floor crying. After about 30 minutes he was calm but a large bump was in the forehead region. The mother watched him for a while then he had an episode of vomiting with stiffening and she brought him to the emergency room where the following CT scan was performed:



How would you describe this CT scan?
What other tests would you recommend?
What is the treatment plan at this time?

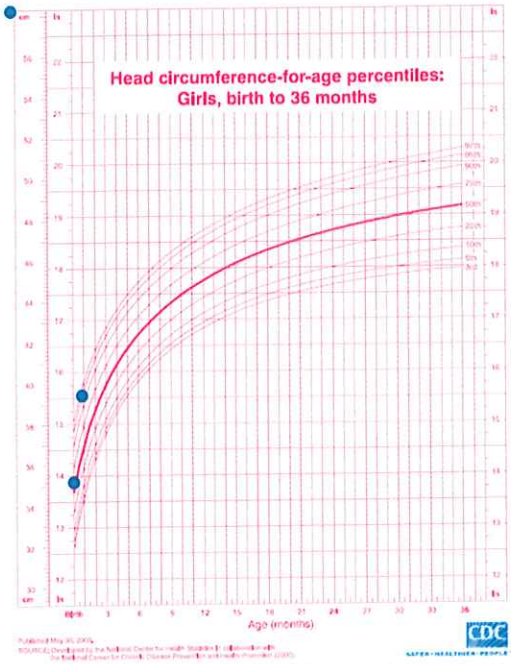
A skeletal survey and ophthalmology exam are performed to assess for suspected non-accidental trauma. There are retinal hemorrhages and what looks like healed rib and right humerus fractures. In terms of your role in neurosurgery, what are the recommendations for follow-up care and management

Article reference:
https://www.clinicalradiologyonline.net/article/S0009-9260(16)30478-0/pdf

3. A 27 year-old-pregnant female presents to clinic when the diagnosis of "something wrong with my baby's back." You review the prenatal MRI which was done at 25 weeks gestation, here is the MRI:

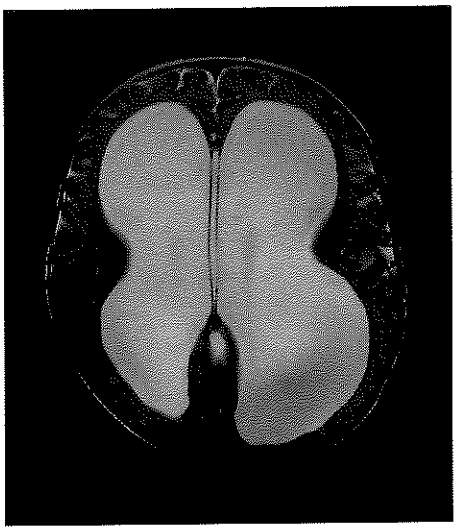
What are you seeing?
How would you describe the MRI and diagnosis with the family?
What are the treatment options?

The baby is born via elective c-section at 38 weeks gestation and is healthy and vigourous. An MRI of the brain and spine are performed at birth. The myelomengiocele is closed the following day. The baby is seen in post-op clinic two weeks later and the incision site is well-healed. You are concerned about the head as the fontanelle feels full but is still springy. You see these findings on the head circumference chart.



What test would you like to do to further evaluate?

The head ultrasound shows progressive ventriculomegaly, though not overt severe hydrocephalus. You order a FAST MRI of the brain in one month. When the baby returns, you see these findings on MRI:



What management would you plan?

When they return in 2 months the ventricles are significantly enlarged. What surgical interventions would you consider at this time?

Pediatric Cardiac Cath Lab APP Student Rotation and New Hire APPs

On-Boarding Objectives APP Pediatric Cardiology/Cath lab

1. Formulate appropriate history questions
2. Perform a detailed physical exam
3. Employ the importance of certain physical exam findings
4. Choose the correct diagnostic imaging modality for different needs
5. Interpret radiology findings appropriately
6. Explain the pathophysiology of different congenital cardiac conditions
7. Utilize educational tools and methods to share knowledge with patients and families
8. Recommend the appropriate pharmaceutical management for different cardiac conditions/pre and post cardiac catheterization
9. Recommend appropriate involvement of other care providers and referrals for patient care management
10. Outline the best treatment modality pre and post procedure

Knowledge:

- Foundational knowledge in subject material
    - Pretest assessment (cases)
    - Educational resources
        - Lectures from APP website (to be created)
        - Example Notes: Admit HP note, Progress notes, Discharge summary.
        - Meetings and conferences
        - Textbooks
    - Post-test (cases)
    - Continuing education
- Applicable knowledge (observation of caths/surgeries, co-rounding, and clinic patient observation)
- Proctored observation of technical skills
- Weekly learning objective of one diagnosis/finding with 2-3 patients from that week that encapsulate that objective
- Documentation-EPIC

"Top 5" Diagnoses in Cath lab:

- ASD
- PDA
- Pulmonary Hypertension
- TOF/PA/MAPCAS and Transcatheter valves
- Cardiomyopathies and Transplants

Educational Resources:

1. Web Resources:
    - CHOP "OPEN" Network
    - CHIP Network
    - Congenital Heart Disease Cardiac Catheterization Manual (PDF)
    - LPCH Intranet
2. Cardiology/Multidisciplinary weekly conferences (schedule managed by Brian Han)
    - Wednesday morning conference @ 0630 (zoom)
    - Thursday am Cardiac Cath Conference @ 0700 (Zoom)
    - Thursday am EP/Cath interventional sessions @ 0730
    - Friday am Surgical Rounds with Dr. Hanley @ 0700 (TBD)
    - ***
3. Conferences:
    - CHIP Network (https://thechipnetwork.org/)
    - TBD with current COVID 19 Crisis
4. Textbooks:
    - Comprehensive list available in "Resources" email folder

Lucile Packard
Children's Hospital
Stanford

PART FIVE

Lucile Packard Children's Hospital Stanford

APP Student Preceptor Handbook

Revised April 2021

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Table of Contents

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

Dear APP Preceptor:

I want to truly thank you for serving as a preceptor for an APP student. I understand the additional work this imposes and the challenge to work this into your busy schedule. APP precepting does bring significant value to you and to our organization. Precepting is an opportunity to realize your own growth and note the vast understanding you have for your specialty. You have much to give to the new learners of our profession. To them, you are an expert as one of the top institutions in the nation and the world. It is an honor for us to share what we know and have learned in this preeminent organization. In addition, it is frequent that student APPs become our future employees. It is for this reason we have added it to the APP Career Ladder. Precepting students can often provide insight as to whether we may want to make the decision to hire these individuals in the future. Precepting also nurtures our relationship with various schools. Please provide the management team your feedback on both the precepting process as well as experiences with individual student and schools and again thank you for serving.

Rebecca Cooner APRN, MS, CPNP-PC
Director of Advanced Practice
Pediatric Nurse Practitioner, General Anesthesia

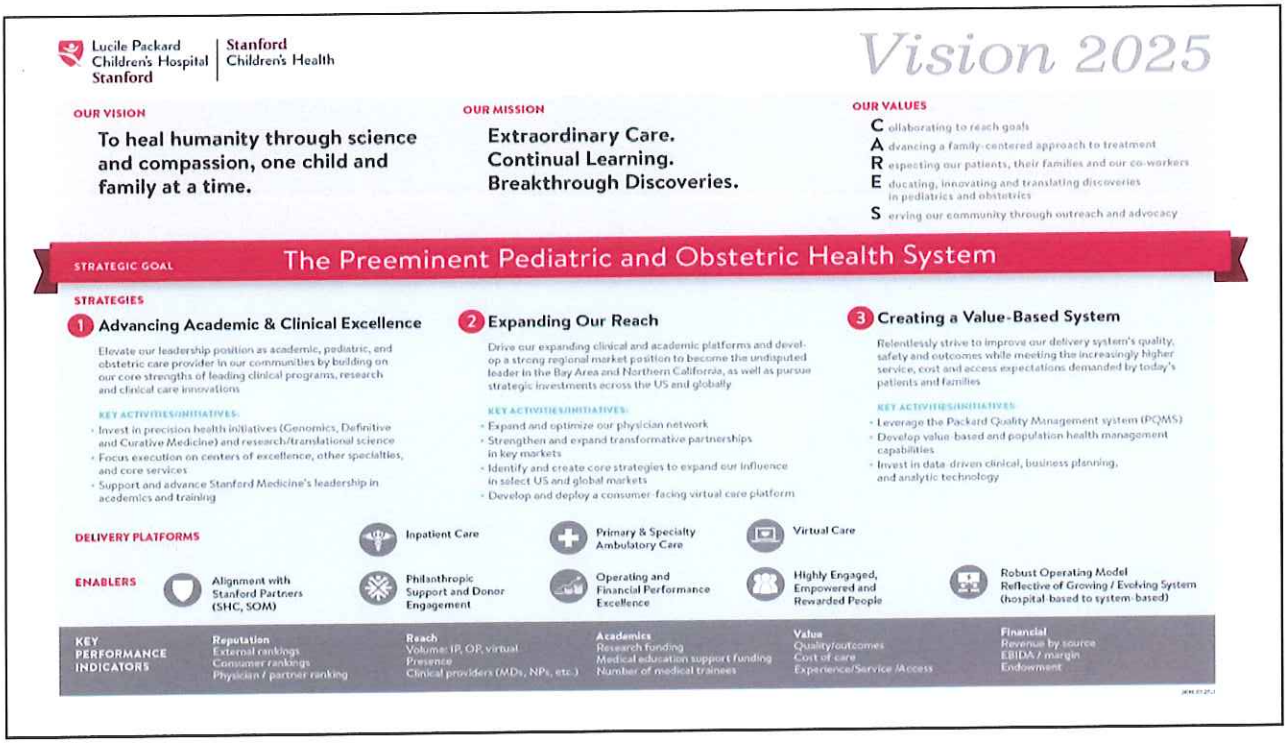
Stanford Children's Health | Lucile Packard Children's Hospital Stanford

LPCH Vision and Mission

Our Vision:
To heal humanity through science and compassion, one child and family at a time.

Our Mission:
Extraordinary Care. Continual Learning. Breakthrough Discoveries.

At Lucile Packard Children's Hospital Stanford and Stanford Children's Health, we developed a 10-year vision to ensure our continued success. This vision, known as Vision 2025, is our strategic road map and establishes a series of priorities aligned with Stanford Medicine. It also builds off our overall Mission and Vision as an organization.



Stanford Children's Health | Lucile Packard Children's Hospital Stanford

PCARES

PCARES is the framework of standards that guides our behaviors and communication with patients, their families and our colleagues, every time. Our goal is to create a welcoming environment for an optimal human experience. These are the values that form a compassionate partnership and team oriented environment to deliver on our promise of providing nurturing care.

P ersonalize interactions:
Use proper names (Mr./Mrs.) or preferred name, introduce yourself, state your role and introduce colleagues.

C ompassionate communication:
Use statements that convey understanding and consideration of the patient, family or colleague experience.

A ssess situation:
Ask patients, families and staff guiding questions, such as *"How can I help you? What concerns you the most today? Have I understood you correctly?"*

R espond promptly:
Respond to questions or requests promptly and anticipate needs. Invite patient, family, or colleague input or perspective. Offer choices when possible.

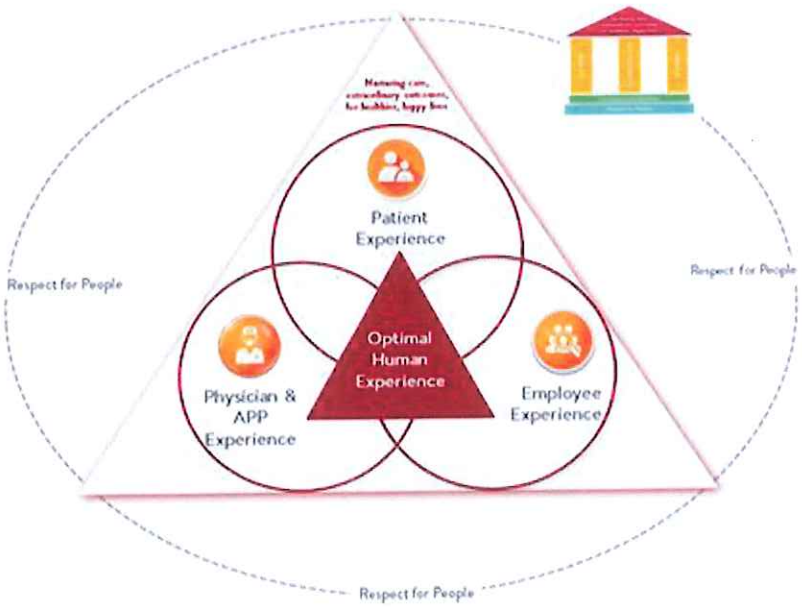
E xpectation setting:
Explain what you are going to do, how long it will take, and how it will impact the patient, family or colleague. Exit courteously with an explanation of what will come next.

S upport the team:
Acknowledge and support the commitment of your co-workers to provide nurturing care. Model trust—speak positively about co-workers and other departments.

Why is PCARES Important?

PCARES is our communication framework which promotes a culture of respect and safety by ensuring a consistent message of concern, appreciation, and safety to our patients and families, and to one another, thus strengthening our foundation for exemplary care. PCARES is the foundation for our continuous communication strategy efforts that will guide us in providing an optimal human experience. This approach:

- **Improves patients' perception of their care**
- **Reduces anxiety, builds patient loyalty**
- **Ensures that staff is delivering the same consistent messages of concern and appreciation**
- **Utilizes 'Words that work' for any interaction**
- **Research shows that this makes a difference to patients**



LPCH APP Center for Advanced Practice

Manager	Clinical Area
Kristine Boyle, NNP	Neonatology, Obstetrics, Reproductive Endocrinology and Infertility, Developmental-Behavioral Pediatrics
Caron Burch, FNP	Heart Failure & Transplant
Carrie Chan, CPNP	Interventional Radiology, Neurology, Neurosurgery, Orthopedic Surgery, Otolaryngology, Plastic Surgery/Craniofacial, Stem Cell Transplant
Sarah Conlon, PA	Liver & Intestine Transplant
Gerri James, RN	Kidney & Lung Transplant
Linda Jordan, PA	Oncology, Neruo-Oncology, Palliative Care, General Surgery, Urology, Pulmonary
Raji Koppolu, CPNP	General Anesthesia, Pain, Rheumatology, Endocrinology, Complex Care, Adolescent Medicine (Teen Van and Eating Disorders), Interventional Radiology, Genetics, Behavioral Immune Health (formerly PANS), Hospitalists, Nephrology, Infectious Disease, Gastroenterology, Hematology
Megan Tracey, CPNP	Heart Center, Critical Care

Preceptor / Student Matching Process

1. Sign up for preceptor bank. Emails to call for preceptors will be sent twice a year. You can also email APPStudentPlacement@stanfordchildrens.org
2. Students will only be matched if there is a contract between LPCH and the school. If a contract is not in place for an interested student, have the school email APPStudentPlacement@stanfordchildrens.org
3. We evaluate every preceptors' request. Students will be matched to preceptors based on background, preceptor request as best as possible
4. Preceptors will receive email with the matched student's information and CV
5. Clinical faculty will send out email to the preceptor directly regarding: clinical competencies, goals of the rotation, course syllabus including objectives, faculty contact, number of hours
6. Students will complete onboarding: receive badge, parking information, and set up EPIC account
    - If there are delays or concerns, students can contact the school or email us directly
    - Preceptors are not responsible for onboarding or badge / EPIC access troubleshooting
7. Set up a time to speak/meet with the student
    - Mutual expectations of conduct: dress code, meeting times, contact information
    - Brief description of the practice and general sense of patient population
    - Individualized student goals – See SMART goals handout
8. Utilize tools provided in this handbook during the rotation
9. Provide written evaluation/site visit as requested by the school.
10. Ask for feedback from clinical placement coordinator on the rotation and any feedback from student (see preceptor evaluation tool)

Stanford Children's Health | Lucile Packard Children's Hospital Stanford

For Interested Preceptors:

Before precepting, ask the following:

- Will you have adequate time spent face to face with patients?
- What space needs are available to meet with students?
- Evaluate personal energy to precept and mentor in light of other professional obligations
- Consider talking with other APP's to split time into shorter rotations: Example: 4 weeks in different specialty rotations

Influences to precept:

- Professional Obligation
- Program information and positive relationships with faculty/school
- Access to program curricula
- Access to clinical resources and references
- Enjoyment of teaching

Barriers to precepting:

- Effect on productivity
- Practice not designed to include students
- Patient's expectations for care provider's attention
- Discomfort with the teaching role
- Short duration of precepting experience (Barker & Pittman, 2010)
- Lack of financial incentive (LPCH APP Survey, 2016)

Questions for Initial Meeting with APP Students

Questions for APP students:

- Are you a PA, FNP, PNP, WHNP, etc? Acute care or primary care trained?
- For PA/FNP students, have you had your pediatric didactic training?
- What courses are you currently taking?
- First or second year rotation?
- How many years of health care experience have you had and in what clinical areas?
- What have been your other clinical subspecialty rotations?
- What are your goals for the rotation? Are there specific objectives you want to achieve?
- Do you need to complete a specific project?
- How do you best learn?

For preceptors, describe your clinical practice to the prospective student:

- How many APP's are in the group? What are their roles?
- Which patient areas are covered? Inpatient/Outpatient/Both?
- What are common diagnosis? Common procedures?
- Where is primary location site?
- Discuss specific learning opportunities: APP lectures, Grand rounds, noon conferences, division meetings, journal club etc...

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Sample Preceptor Letter to Students

Hello!

Welcome to your clinical rotation at the Stanford Children's Health [practice area]. I have had an opportunity to review your CV and look forward to working with you [insert quarter/year].

I have a few questions for you:

1. Which DATES AND TIMES are you planning to come to clinic?
2. Do you speak any languages other than English?
3. Please tell me 3-5 specific goals for this quarter in [specialty clinic]? (For example, what procedures do you want to see or perform? What conditions would you like to expand your knowledge on?)

Here is some information that you might find useful for your rotation at [specialty clinic]:

1. The best way to reach me is ***
2. Clinic address: ***
3. Front desk phone number : ***
4. You must wear your Stanford ID badge at all times.
5. Dress is [business casual/scrubs]
6. Epic access to be arranged during onboarding. Expect to do some charting!
7. There is a lunch room with a refrigerator/freezer, water, ***. We break for lunch sometime between *** for *** minutes depending on how our day is going.
8. During your rotation, I will be here for all except the following dates: ***
9. If you need to make up hours, you are welcome to come to [other clinic availabilities here if applicable]
10. In addition to seeing patients, there will be times where I am triaging patients, returning phone calls, coordinating care. This is also a vital part of patient care.
11. I would recommend that you review the following before your first clinic to prepare you for your first day in [this specialty]:
    - ***

I can't wait to meet you and start your clinical rotation.

Sincerely,

Rotation Objectives

Student Responsibilities:

While each program may have some variations in clinical competencies, these are some general competencies to keep in mind:

- Become familiar with the steps in diagnosis and treatment/referral needs of the pediatric patient
- Elicit & document a history from assigned patients and families
- Perform & document a physical exam pertinent to the patient's clinical condition
- Perform & interpret laboratory and diagnostic studies
- Recognize and assess emergent and routine disease processes
- Develop interpersonal skills in regard to respectful interactions with patients and their families
- Communicate effectively with members of the team and other services
- Evaluate, develop, and understand clinical management plans
- Gather essential and accurate information on the patient's clinical condition, diagnosis and present patient appropriately
- Document H&P, progress notes as appropriate
- Research current evidence to guide clinical care
- Familiarize with local, state, ad federal rules & regulations on APP practice

Preceptor Responsibilities

- Orient student to the clinical site and policies
- Direct goals & objectives based on learning outcomes provided by the faculty
- Facilitate a collaborative & mutually respectful environment
- Evaluate whether learning needs are met
- Be up to date with current practice to teach student
- Provide ongoing feedback to improve APP student's clinical progress
- Direct APP student to resources and readings to augment their learning
- Notify faculty and student of any concerns about student behavior, skills, or progression
- Model safe clinical practice and professional behavior
- Determine best method of communication with APP student, and being flexible in teaching

Preceptor Tips

Teaching Techniques:

- Introduce student to patient's family. If a family is unsure about having a student evaluate their child, provide support to say the patient was chosen as an important example of a skill or condition about which the student needs to learn, and that the preceptor will be with the student
- Case discussions
- Matching patients and the student for a specific learning experience
- Direct questioning and observation
- Assignment of direct readings, and assign patients with that specific diagnosis at next clinic date
- Recommend a few good overview articles that represent conditions & assessments common to the specialty patient population
- Try to group diagnoses to help student better organize learning, i.e. spinal cord defects
- Continue to emphasize normal child development and age appropriate normal

One Minute Preceptor Model (Neher, Golden, Meyer, & Stevens, 1992)

This method allows the preceptor to understand the APP student's critical thinking pattern, communicates general rules of the encounter and provides immediate feedback.

FIVE STEPS

1. Get a commitment: the preceptor will ask the student their interpretation of the problem or case by asking a few simple questions.
    a. Ex. What do you think is going on? What other assessments do you have?
2. Probe for supporting evidence and underlying evidence supporting the student's commitment. Encourage the student to think out loud to assess decision making skills and knowledge
    a. Ex. What led you to that conclusion?
3. Teach general rules. If the student is incorrect in their assessment or missing key information, the preceptor can provide needed information and resources.
    a. Ex. Many times when...
4. Reinforce what was right and provide positive feedback that is specific to what the student did corectly
    a. Ex. You did an excellent job of...
5. Correct mistakes and make recommendations for improvement

Tips for Outpatient Time Management:

- Preview next day patient list to be familiar with patient complexity of the visit to enable you to appropriately assign patients to the student
- Email student several days prior to the clinical day with suggestions of diagnosis. This will aid the student in learning during clinic if they have at least some background knowledge of the medical condition
- Start with student shadowing the preceptor until you feel comfortable. Consider where they are in their training in terms of their level of confidence and autonomy. The value of shadowing should not be underestimated, as this is the primary way for preceptors to model their style with patients. (Barker & Pittman, 2010)
- Progress to students taking a patient history independently with presentation to preceptor. Then you can work on phone calls, labs result view, emails while student is in the room
- Talking out loud when you are billing, note writing, test ordering provides an opportunity for the student to hear the preceptor's train of thought (Barker & Pittman, 2010)
- Consider double booking patients so the APP student can start with one patient while you start with another
- Focused half days: Preceptor selects 1-2 patients for the student to concentrate on based on age, condition, assessment skills, of aligned with objectives of the course. This may be less overwhelming for the student and keeps the preceptor on course.

Tips for Inpatient Time Management:

- Review inpatient list for appropriate patients; consider focusing one day on new admits/post-ops, another on discharges & teaching
- Have the student focus on one patient initially to complete expected documentation by the NP
- Model collaborative practice, communication with consulting services, communication on rounds, following up on ordered tests
- Observe procedures & surgeries, as appropriate
- Utilize one-minute preceptor to help student think about diagnoses and come up with treatment plan, and allow time for teaching

Tips for Student Evaluation:

- Give feedback throughout the rotation
- Based on performance, not personality
- Be honest and constructive
- Communicate to faculty in a timely manner
- Mutually devise a strategy for improvement
- Use SMART goals to help evaluate if student is progressing in clinical rotation appropriately
- Communicate positive feedback
- Describe problem, approaches to rectification, and progress achieved

SMART Goals - Setting up Goals with the Student

- Specific: What / who exactly is involved?
- Measurable: How will we know if the goal is achieved?
- Attainable: Can it be done in the proposed timeframe?
- Relevant: Do we have resources to achieve this goal?
- Time-Based: When should this goal be achieved?

Long-Term:

- Identifying what the student should learn by the end of the preceptorship
- *Instead of: I want to be a better provider*

SMART goal examples:

- Over the next 3 months, I will practice performing comprehensive physical examinations, that are age-specific, to identify any concerns.
- By the end of the preceptorship in 3 months, I will be able to come up with at least 3 differential diagnoses for each patient
- In 2 months, I will be able to write a comprehensive H&P, by asking pertinent +/-, review of systems, and practicing writing one every week.

Short-Term:

- Can be the goals for the next week(s), or for the day
- *Instead of: I want to learn more about the patients*

SMART goal examples:

- For the next two weeks, I will focus on reviewing the labs of one patient, and identifying any abnormal labs, and explain reasons why this may have occurred
- Today, I will be able to concisely present to my preceptor on 2 patients.
- By next week, I will be able to write progress notes / clinical notes for 2 patients

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APP Student Note Writing at LPCH

Audience: APP Students, Supervising APPs

Summary: Due to CMS policy changes in 2018, the teaching APP may use APP student documentation for billable services provided that:

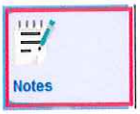
- Physical presence requirements are met
- Teaching APP satisfies the performance requirement and verifies the documentation

This applies to APP student documentation for Admission H&P, Progress Notes (Inpatient and Ambulatory), Consult Notes, and Discharge Summaries.

Note APP student notes CANNOT support certain billing charges (e.g. critical care, intensive care, prolonged services, medical team conferences, and psychiatric collaborative care management codes)

APP Students:

1. Go to the Notes activity and create a new note.

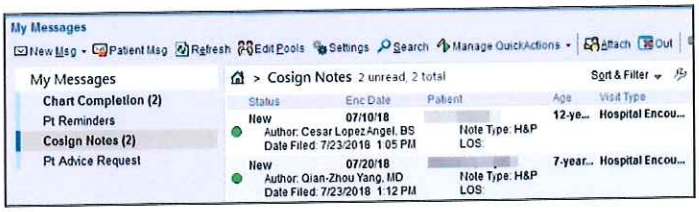


2. After selecting the appropriate note type, add the supervising APP as a cosigner. The appropriate cosigner will be determined by your team.

3. At the bottom of the note, APP students should include their name, title, and year.

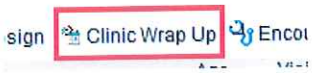
4. Once the note is complete, sign the note to route to the cosigner.
   a. For inpatient notes, click Sign button
   b. For outpatient notes, confirm drop down is set to Sign on close

Supervising APPs:



1. Supervising APPs, assigned as cosigner for the note, receive an InBasket message in the folder named Cosign Notes.
2. The note can be edited and cosigned by the supervising APP by opening it from the InBasket
   a. APP can use attestation upon signing the note
   b. Smart phrase is "APPSTUDENTATTEST" →I saw and examined the patient and discussed his/her management with the APP student. I reviewed the APP student's note and agree with documented findings and plan of care.

3. If needed, APPs can add their attending as cosigner when editing the note.
4. Outpatient encounters can be closed by using the "Clinic Wrap Up" tab.



Summary of Workflow:

Type of Visit	Workflow	Cosigner	Who has final ownership of the note?
Shared Visit	1. Student creates a note in the encounter 2. Student indicates APP as the cosigner and signs note 3. APP addends the note, adds attending as cosigner, and then signs the note 4. Attending addends and signs the note	1st- APP Final - Attending	Attending
Independent Visit	1. Student creates a note in the encounter 2. Student indicates APP as the cosigner and signs note 3. APP addends and signs the note	APP	APP

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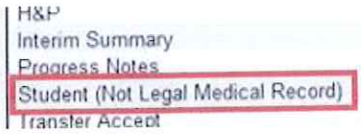
APP Students working in ICUs

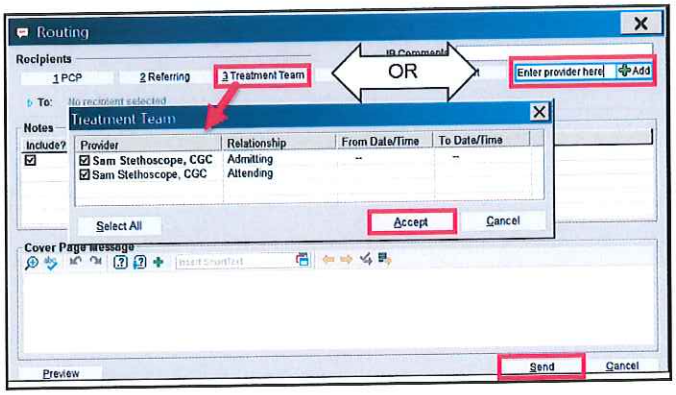
APP students working in ICUs should continue to use the APP Student notes as these notes will NOT be used for billable services.

1. **Select the Student note type**



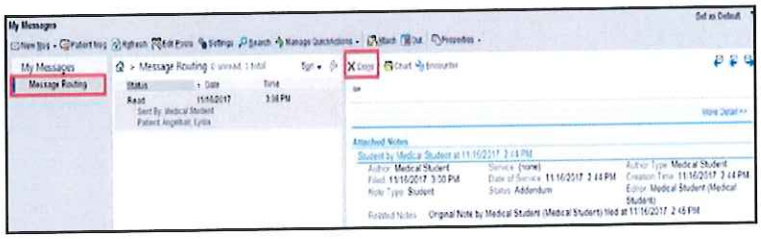
2. **Once note is completed, click the Sign button.**

3. **APP students should route the note manually to the person responsible for reviewing the note (supervising APP).**
   a. **click Route from the toolbar to route the selected note to the supervisor**



4. **From the Routing window, select the recipients by either clicking the Treatment Team button to select the provider, or enter the provider's name under the search field, and then Send when done.**

5. **The routed APP student note will appear in the designated provider's In Basket - Message Routing folder. The supervisor will select the note and click Done after they've reviewed the note.**



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Recommendations for Tele-Precepting

Ensure that student has completed Healthstream modules. Schedule a 20-30 minute meeting with student to introduce yourself, your clinic and, telehealth:

Some Topics to go over regarding telehealth:

- Uses for telehealth:
  - Post op care
  - Wound assessment
  - General Follow up care
  - Same day additions or in person conversation
- Billing
  - Billed by time
  - Audio and video required to be billable
  - Patient must be present during telehealth to be billable
- Licensing
  - Patient must be physically located in the state in which you have a medical license (this is currently lifted due to COVID-19 but may go back into effect in the future)
  - Established patients temporarily traveling for vacation may receive care via telehealth
- Patient Consent
  - Per CA state law, provider must receive verbal or written consent from patient prior to start of visit to confirm they are okay to proceed with the telehealth visit, should be documented in the note
  - Document teleconsent dotphrase in all notes
- Webside manners
  - Make eye contact with camera and not the screen
  - Ensure you have a quiet/private place during visit to maintain patient privacy
  - Have work badge visible on camera
  - Remember actions are magnified, do not eat or drink during visit
- Tips for having students in visit
  - Prior to each visit have a plan/schedule of how the visit will go
  - Introduce the student to the family
  - Ask permission from family for student to be present during visit
  - Ask permission from family for student to take history/ask questions
  - Verbalize to the family how the visit will go
- Webex (via epic) does not allow multiple providers to be on the call, so the student would have to be physically with you to be present for the visit if using WebEx. Zoom allows you to have multiple providers on the call

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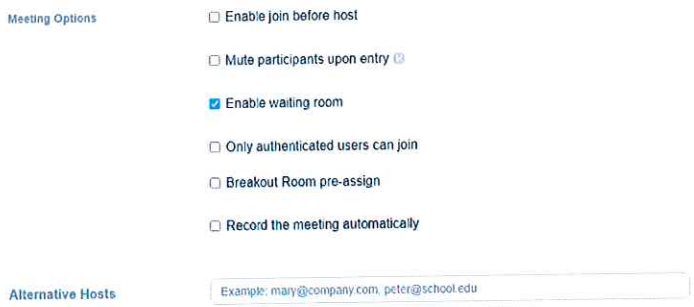
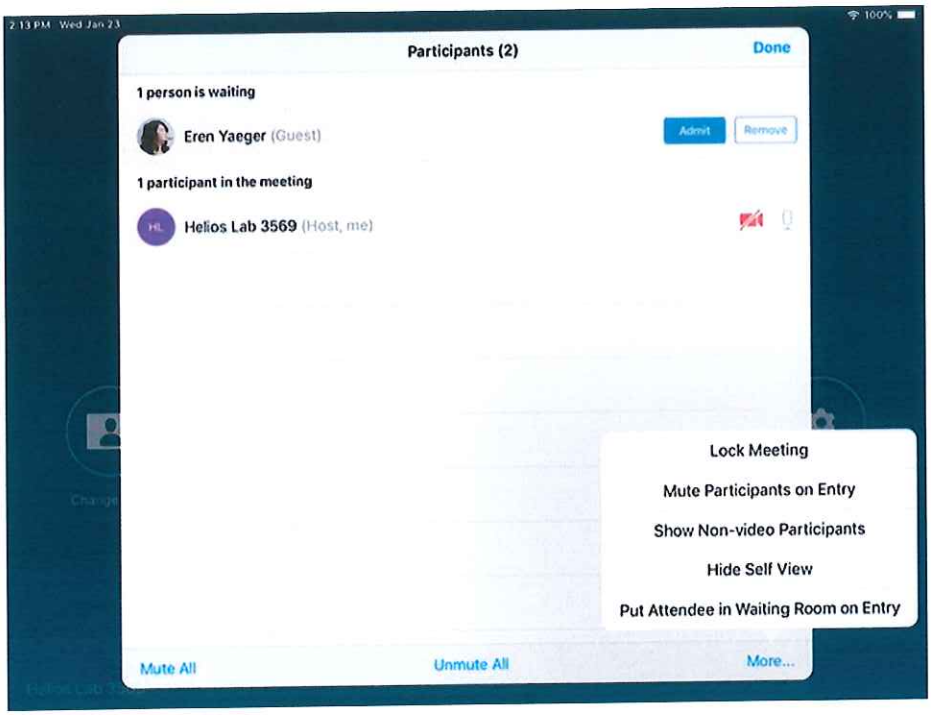
Zoom Tips for Precepting

- Utilize share screen function to navigate Epic and chart review with your student
- Turn off microphone if you are in a space where other noise may be heard.
- If you are the host of the zoom you can enable the waiting room to have patient discussions either before, after, or during your meeting.
    - If you are not the host of the meeting, the administrator who sets up the zoom will have to make you the host to enable these features.



Enabling or Disabling Waiting Room during a Meeting:

1. As the meeting host, tap manage participants
2. Click **More** at the bottom of the participants' window and tap **Put Attendee in Waiting Room on Entry** to enable the feature



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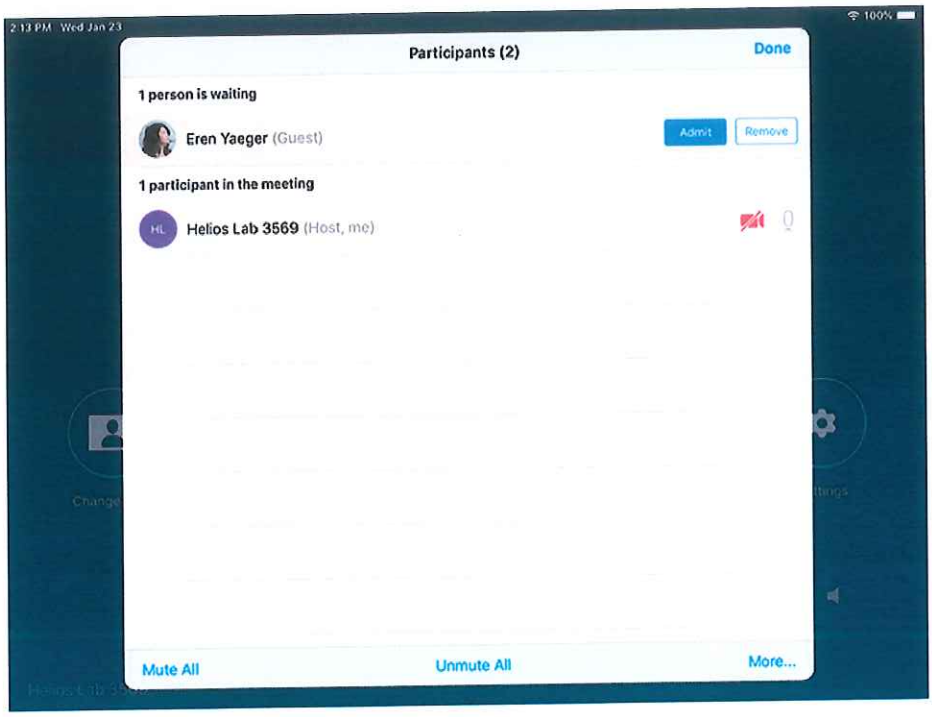
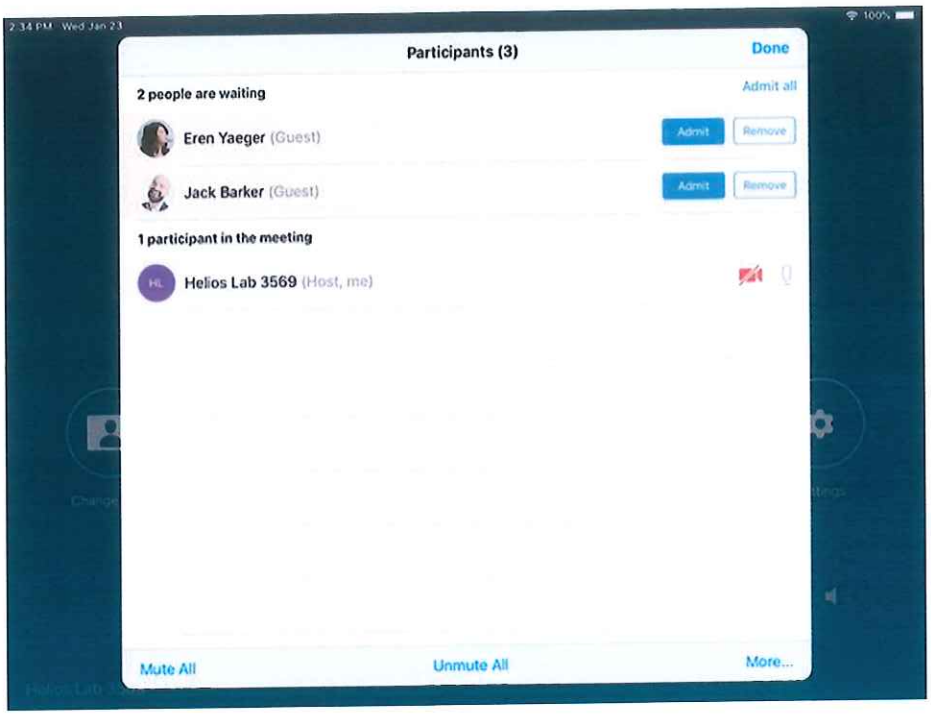
Admitting Participants During a Meeting

1. As the meeting host, tap **Manage Participants**
2. Tap **Admit** to have the participant join the meeting



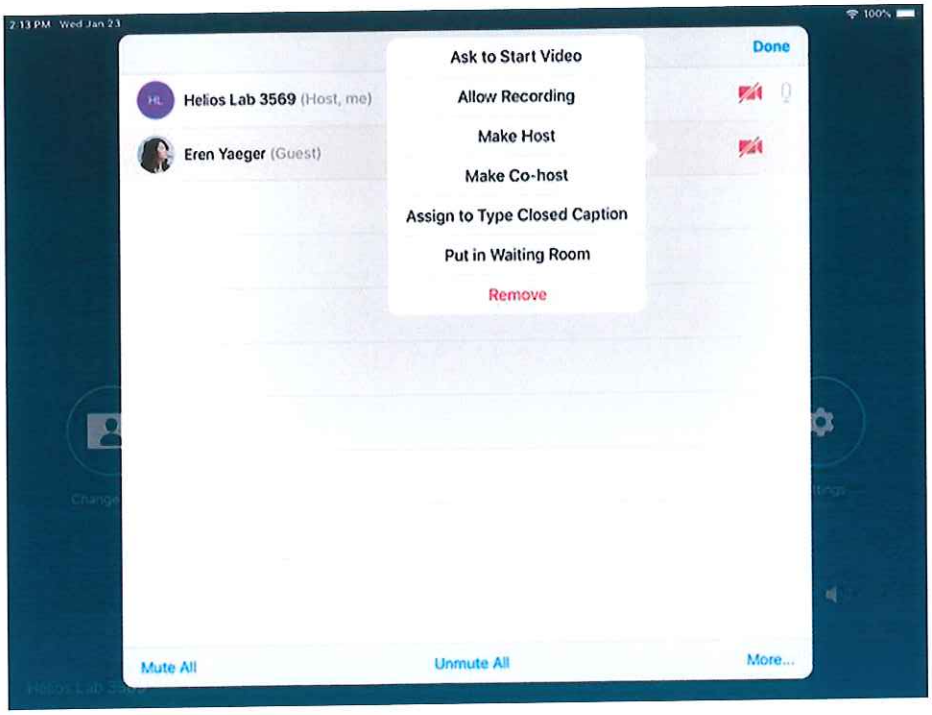
Admit all participants from the Waiting Room

1. As the meeting host, tap **Manage Participants**
2. Click **Admit All**



Sending participants to the waiting room during a meeting

1. As the meeting host, click **Manage Participants**
2. Tap the participant's name and choose **Put in Waiting Room**



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Lucile Packard Clinical Site Evaluation Form

Name of Student: _____
Clinical Specialty: _____
Dates of Rotation: _____
Preceptor: _____
University: _____

Instructions: Please use the following scale to answer the below question:

1: Strongly Disagree 2: Disagree 3: Neutral 4: Agree 5: Strongly agree

Educational Value:

a)	Overall level of teaching was appropriate for me	1	2	3	4	5
b)	My experience correlated to school's objectives	1	2	3	4	5
c)	I was able to see a variety of patient conditions	1	2	3	4	5
d)	I had access to conferences/literature	1	2	3	4	5

Clinical Value:

a)	I provided enough hands on patient care to feel confident in my skills	1	2	3	4	5
b)	I was able to perform procedures as appropriate to my objectives	1	2	3	4	5
c)	I was given responsibility appropriate to my training	1	2	3	4	5

Preceptor/Staff:

a)	I felt acceptance as a member of the team	1	2	3	4	5
b)	I felt the relationship with the preceptor (s) was adequate to help me learn	1	2	3	4	5
c)	The relationship with team members supported my clinical experience	1	2	3	4	5
d)	I felt the level of preceptor supervision was appropriate to my knowledge	1	2	3	4	5

Other:

a)	I was adequately oriented to my role	1	2	3	4	5
b)	The clinical experience met my learning needs	1	2	3	4	5
c)	Overall rating of the rotation	1	2	3	4	5

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Resources for Preceptors

APP Preceptor Resources are available on the APP Website:

https://stanfordchildrens.sharepoint.com/sites/ConnectAnywhere/PatientCareServices/app/Pages/default.aspx

Visit the website to view and download: Under "Professional Development" then "Preceptor Resources"

- Teleprecepting Tip Sheet
- Video to the 5 Minute Preceptor
- APP Student Note writing and Preceptor attestation
- Information about our LPCH workshop
- Setting up SMART goals

References

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Stanford Health Care

Advanced Practice Provider Onboarding & Orientation

Preceptor Packet

Name of New Hire APP: _____

Name of APP Preceptor: _____

Dates of Orientation Period: _____

_____

Date

Dear Preceptor,

Thank you for agreeing to serve as a preceptor for the Advance Practice Provider (APP) Orientation Program. You are one of the most important parts of this program. The guidance and appraisal you provide is instrumental to the newly hired APP's success. A packet has been put together to help guide you through the requirements and expectations of the preceptor during the orientation period. The documents include:

- **APP Preceptor Role Description**
  - Details the role and the responsibilities of the preceptor
- **APP Preceptor Record of Onboarding & Orientation**
  - This form is maintained until the end of orientation to be sure the new hire orientation experience is representative of the activities and role responsibilities they can expect to encounter in their job.
- **APP Preceptor Orientation Meeting Agenda Guidelines**
  - This form is a guideline for an initial meeting agenda to help facilitate communication between the preceptor and the new hire.
  - Use and modify this form to provide information the new hire will need to be successful in their role and set clear expectations of what to expect during orientation.
- **APP New Hire Appraisal form**
  - Use this form as a tool to evaluate progress.
  - May include feedback from other colleagues who assist in orientation progress.
  - Provide bi-weekly updates to Manager.

Again, thank you so much for agreeing to be a preceptor. If you have any questions or need help of any kind please feel free to reach out to your supervising manager or the Director of Advance Practice

Sincerely,

_____

Department/Service Manager

***Garrett Chan*, PhD, APRN, FAEN, FPCN, FNAP, FAAN**
Director of Advanced Practice
Clair Kuriakose, MBA, PA-C
Manager of Advanced Practice

Advance Practice Provider Onboarding

An introductory stage in the process of new APP integration beginning at the time of new hire offer acceptance and continuing through the first 2 weeks of employment. The content and instruction are generalizable across practice settings.

Major Objectives: (1) Welcome to Stanford Hospital & Clinics and department. (2) Reduce anxiety. (3) Understand organizational expectations. (4) Understand role specific expectations. (5) Complete administrative start up activities.

Advance Practice Provider Orientation

A formal process to transition APP into specific role. Overlaps with onboarding and continues for the first 12 weeks of employment. Learning and training is tailored to specific job role.

Major Objectives: (1) Establish & document role specific competence. (2) Introduction to organizational and system resources. (3) Peer networking and socialization. (4) Establish preceptor relationship. (5) Role immersion. (6) Progress appraisal.

Advanced Practice Provider
Preceptor Role Description

I. Role Summary

A preceptor is an experienced staff member who orients new staff to the roles and responsibilities, policies and procedures, of his/her assigned role.

This includes introducing the orientee to the formal and informal rules, policies and procedures, customs, social and professional culture within the work environment. A preceptor teaches, coaches, role models, and supports the growth and development of the orientee. Preceptors should demonstrate exceptional skills in giving and receiving feedback, performing assessments, organizing and prioritizing activities, evaluating teaching and learning needs, and creating a supportive learning environment to promote the orientees' success.

II. Preceptor Role Criteria

The APP is ready to assume the role of preceptor when the following criteria are met:

1. Indicates a willingness to accept the responsibilities of the role of the preceptor.
2. Provides patient care and/or performs his/her role according to department standards and hospital policies.
3. Works well with other members of the health care team.
4. Uses resources effectively and appropriately.
5. Demonstrates effective communication skills.
6. Demonstrated appropriate organizational and priority setting skills.

III. Preceptor Role Responsibilities

1. Assess learning needs and learning styles of orientee.
2. Plans orientation experiences to accomplish the goals and objectives of the orientation program within the established orientation time frame.
3. Teaches the orientee routines, expectations, policies and procedures according to department and hospital standards.
4. Provides useful, constructive, and timely feedback throughout the orientation period in a thoughtful and non-threatening manner.

5. Provides opportunities for the orientee to gain independence in his/her role.
6. Evaluates and documents attainment of objectives and competencies.
7. Assists the new hire to feel welcome and facilitates integration into the peer group.
8. Seeks feedback on teaching methods and ability and integrates changes as needed.
9. Recognizes when the interpersonal relationship between the preceptor and orientee needs to be modified or is not effective for growth and makes appropriate. recommendations or changes.

IV. Preceptor Assignment

1. The preceptor should be assigned no more than one orientee at a given time.
2. The preceptor should be assigned the same schedule as the orientee when possible to provide continuity and frequent opportunity for communication and support.
3. When possible the preceptor work assignment should be lightened to allow time for teaching and feedback.

Advanced Practice Provider
Preceptor Record of Onboarding & Orientation

	Onboarding Pre-Arrival Activities	Comments	Date Completed	Preceptor Initial
1	**Pre – Arrival Phone Call** • Welcome new hire to department and service • Explain preceptor role in the 12 week orientation process • Set expectations for bi-weekly appraisal • Set date and time of initial meeting • Provide contact information • Assist with questions			

	Orientation Activities	Comments	Date Completed	Preceptor Initial
1	**Evaluate & Document Role Specific Competence** • May include but is not limited to:			
	• Observe & evaluate role specific competence in accordance with department and hospital standards • Complete bi-weekly appraisal form • Acknowledge and reinforce areas orientee is doing well • Keep Manager and Director of APP Practice informed of any areas of concern			
2	**Introduce to Organizational & System Resources** • May include but is not limited to:			

	• Hospital Resources
	  ○ APP General Council
	  ○ Nursing Grand Rounds
	  ○ Shared Governance Councils
	  ○ Center for Professional Development & Education
	  ○ Hospital Org Chart
	  ○ EPIC tools and tricks
	  ○ Intranet
	• Department Resources
	  ○ Conference/Meeting rooms
	  ○ Department Meetings & Councils
	  ○ Rounding Schedule if applicable
	  ○ Sub-Specialty meetings if applicable
	• Hospital & University Amenities
	  ○ Places to eat and meal discount card
	  ○ Gym and Recreation Facilities
	  ○ Parking & Transportation Resources			

3	**Peer Networking and Socialization** • May include but is not limited to:			
	• Introductions to Department Staff • Introductions to Sub-Specialists • Provide department contact lists • APP monthly lunches • Journal Club, peer review, other activities if applicable • HIP classes			
4	**Establish Preceptor Relationship** • May include but is not limited to:			
	• Provide contact information: phone, email, pager and be accessible to orientee • Evaluate orientee learning needs and learning style • Meet with orientee at least weekly, more often as appropriate			

	• Provide non-threatening feedback			
5	**Role Immersion** • May include but is not limited to:			
	• Provide increasing opportunities for independent practice over 12 week period • Use Record of Onboarding and Orientation to ensure experiences are representative of the activities and role responsibilities orientee can expect to encounter in their job including but not limited to: o Procedures o Diagnostic modalities o Lab Work o Patient Visits o Patient Education o Consults/Referrals o Documentation o Placing orders o Medication titration o Department and Hospital Communication o Standard Workflow o Staff Education			
6	**Progress Appraisal**			
	• Utilize appraisal form to provide bi-weekly written documentation of progress • Maintain ongoing communication and feedback			

Advanced Practice Provider
Preceptor Orientation Meeting Agenda Guidelines

Purpose of New APP and preceptor meeting:
To facilitate open communication between the new hire APP and APP Preceptor; provide information the APP will need to be successful in their role, and set clear expectations on their role and performance.

	Agenda Item	Notes
1	Contact Information & Communication • Phone(s), pager, and email • Preferred method for routine and urgent communication	
2	Evaluation & Appraisal • Frequency and format of meetings/feedback • Meeting times • Review Appraisal Form • Review Record of Orientation • Review preceptor and new hire expectations	
3	Assess learning style and learning needs • Previous experiences • Knowledge gaps • Strengths	
4	Preceptor provide insight • Nuances of role and department • Culture of department and hospital • Tips to be successful in orientation period	
5	Orientation Schedule • Review outline of 12 week plan to complete role immersion • Colleagues and contacts to assist with orientation	

Advanced Practice Provider
Preceptor Appraisal Form

The development of clinical evaluation standards for APPs is in progress. In the meantime, appraisals should be based upon the specific job description, appropriate privileges and the CI-Care World Class Practices. These practices are outlined in Success Factors and include Compassion and Caring, Professionalism and Pride, Teamwork and Communication.