Getting the MOST out of YOUR Academic Half Day

.Your mission… is to be a phenomenal doctor……

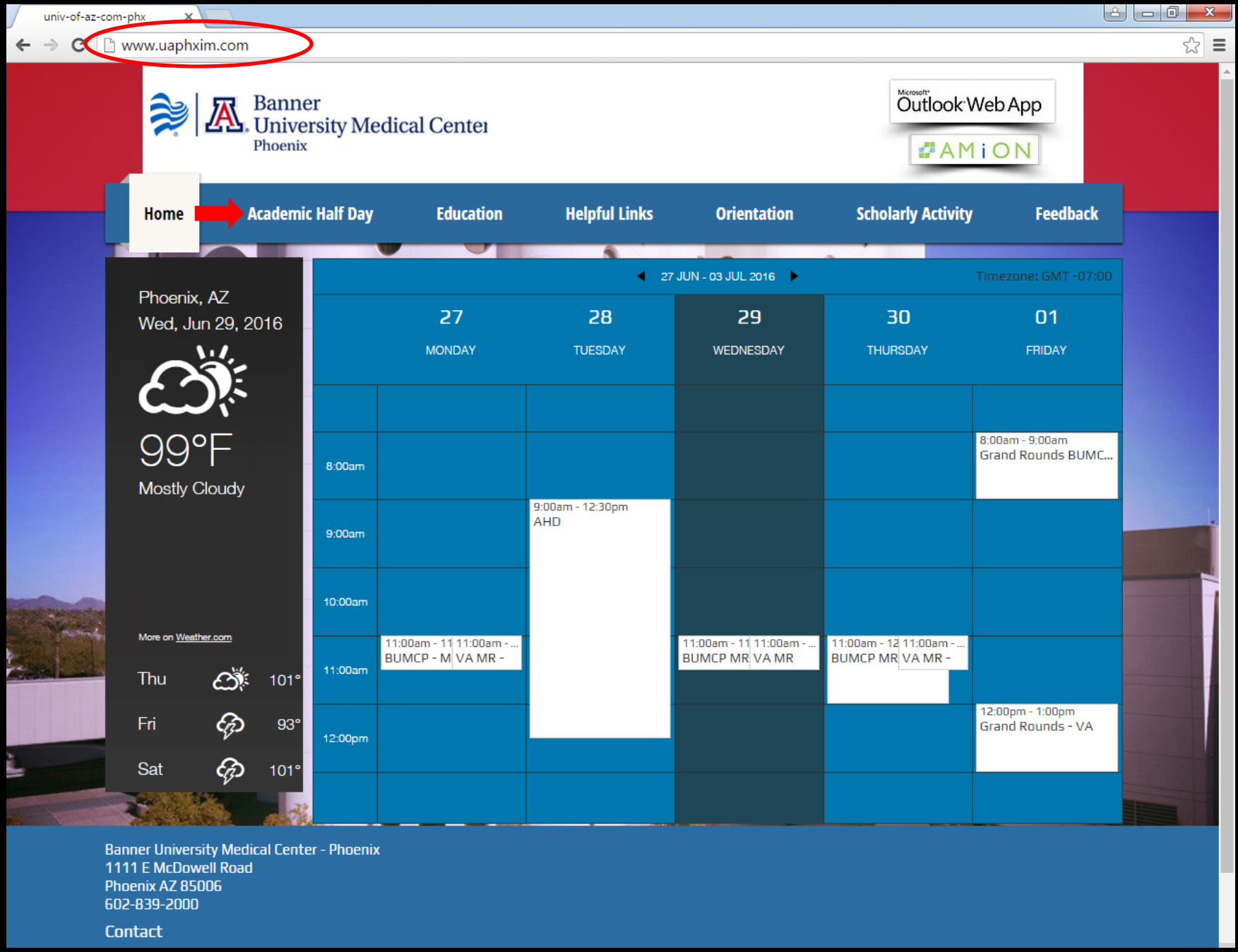
IT IS NOT IMPOSSIBLE!

It will be a marathon…

and require intensive training, discipline, and planning on your part….

Academic Half Day (AHD)

- 9:15-12:30 Tuesday mornings
- All clinical services covered by attendings while you learn, uninterrupted
- Learn from the experts!
- Articles/ Objectives/ MKSAP questions
- Board preparation/ Patient care
- This is your job! *You are being paid* approximately $5,000 to attend *per year!*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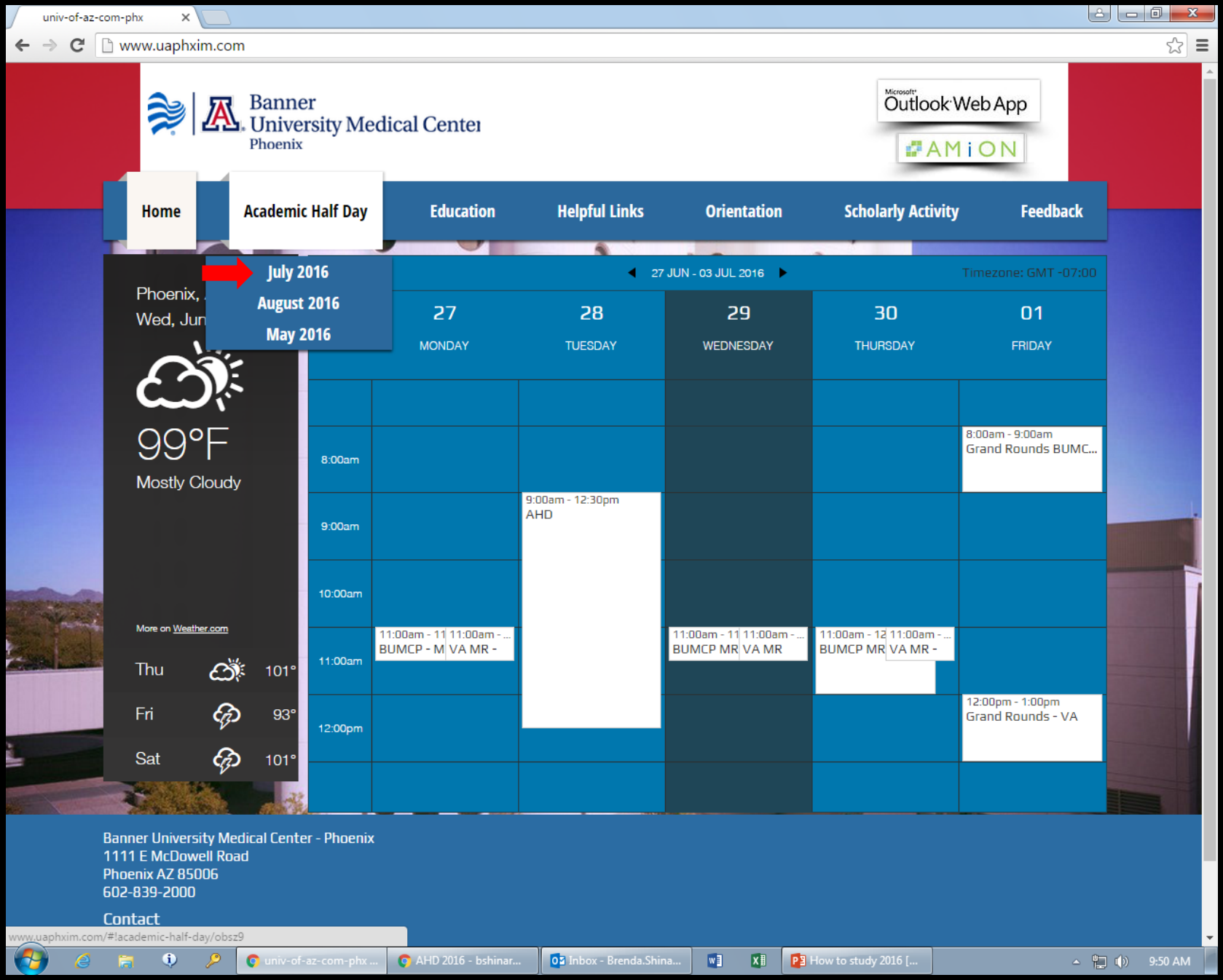
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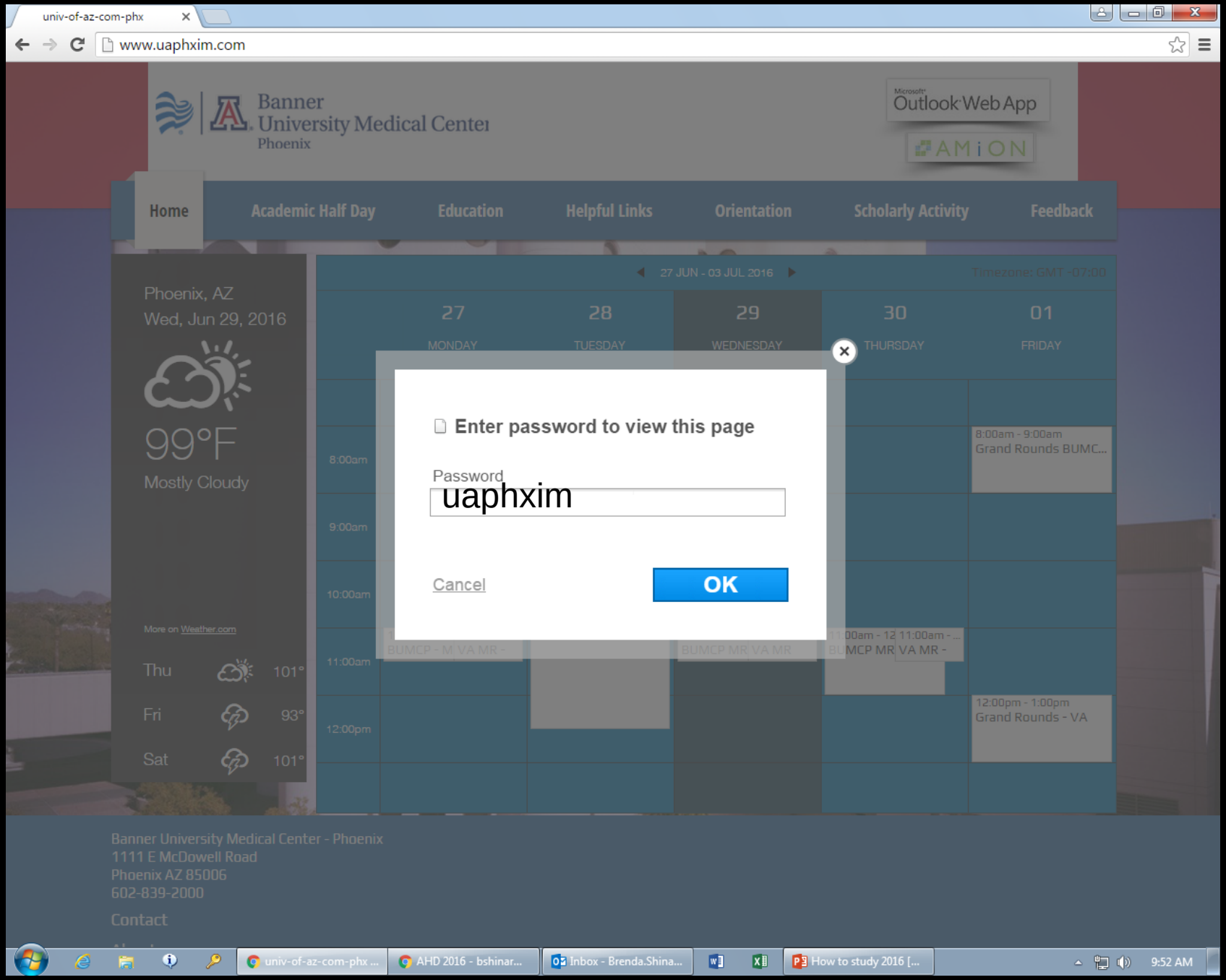
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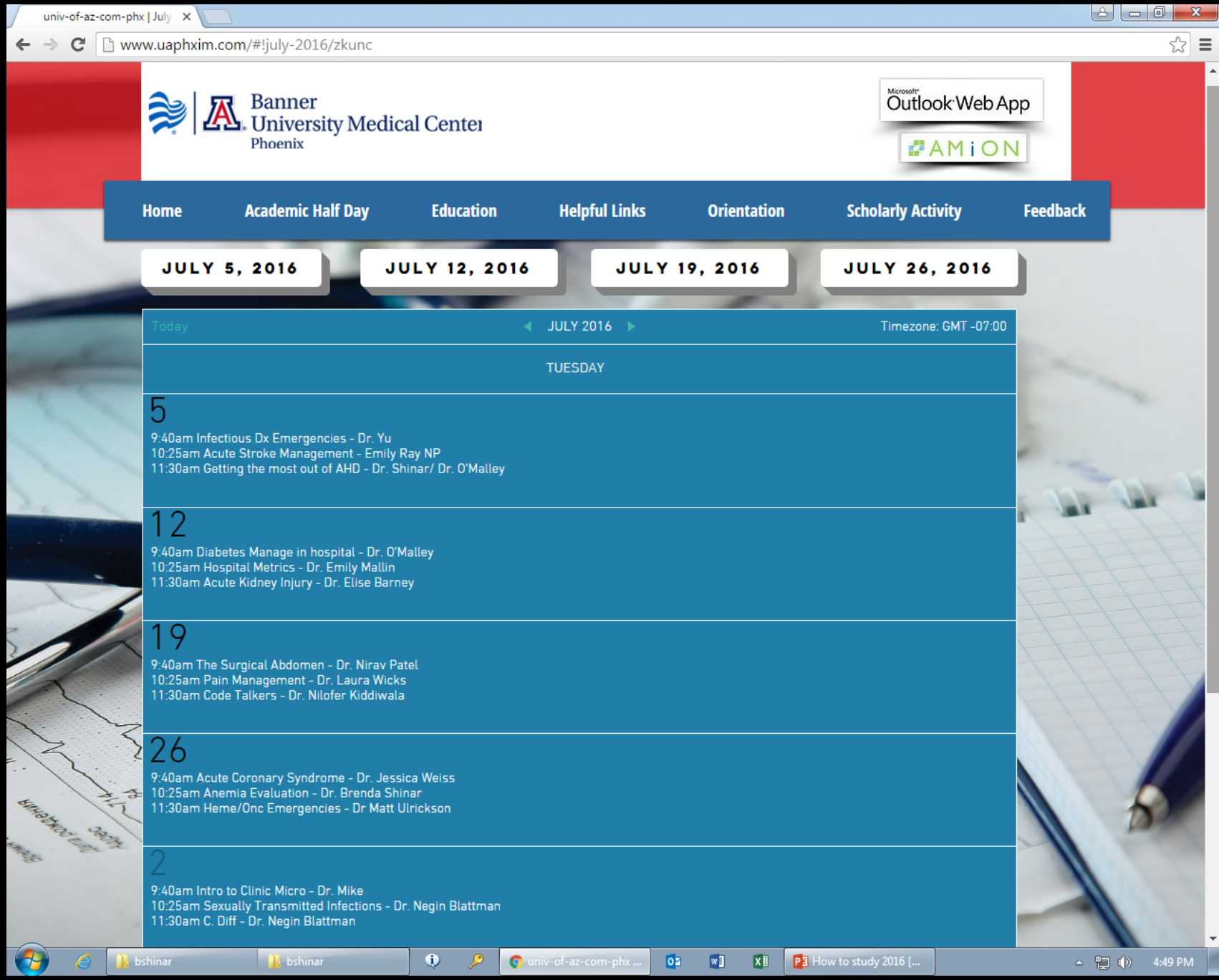
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JULY 2016
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TUESDAY
5
9:40am Infectious Dx Emergencies - Dr. Yu
10:25am Acute Stroke Management - Emily Ray NP
11:30am Getting the most out of AHD - Dr. Shinar/ Dr. O'Malley
12
9:40am Diabetes Manage in hospital - Dr. O'Malley
10:25am Hospital Metrics - Dr. Emily Mallin
11:30am Acute Kidney Injury - Dr. Elise Barney
19
9:40am The Surgical Abdomen - Dr. Nirav Patel
10:25am Pain Management - Dr. Laura Wicks
11:30am Code Talkers - Dr. Nilofer Kiddiwala
26
9:40am Acute Coronary Syndrome - Dr. Jessica Weiss
10:25am Anemia Evaluation - Dr. Brenda Shinar
11:30am Heme/Onc Emergencies - Dr Matt Ulrickson
2
9:40am Intro to Clinic Micro - Dr. Mike
10:25am Sexually Transmitted Infections - Dr. Negin Blattman
11:30am C. Diff - Dr. Negin Blattman
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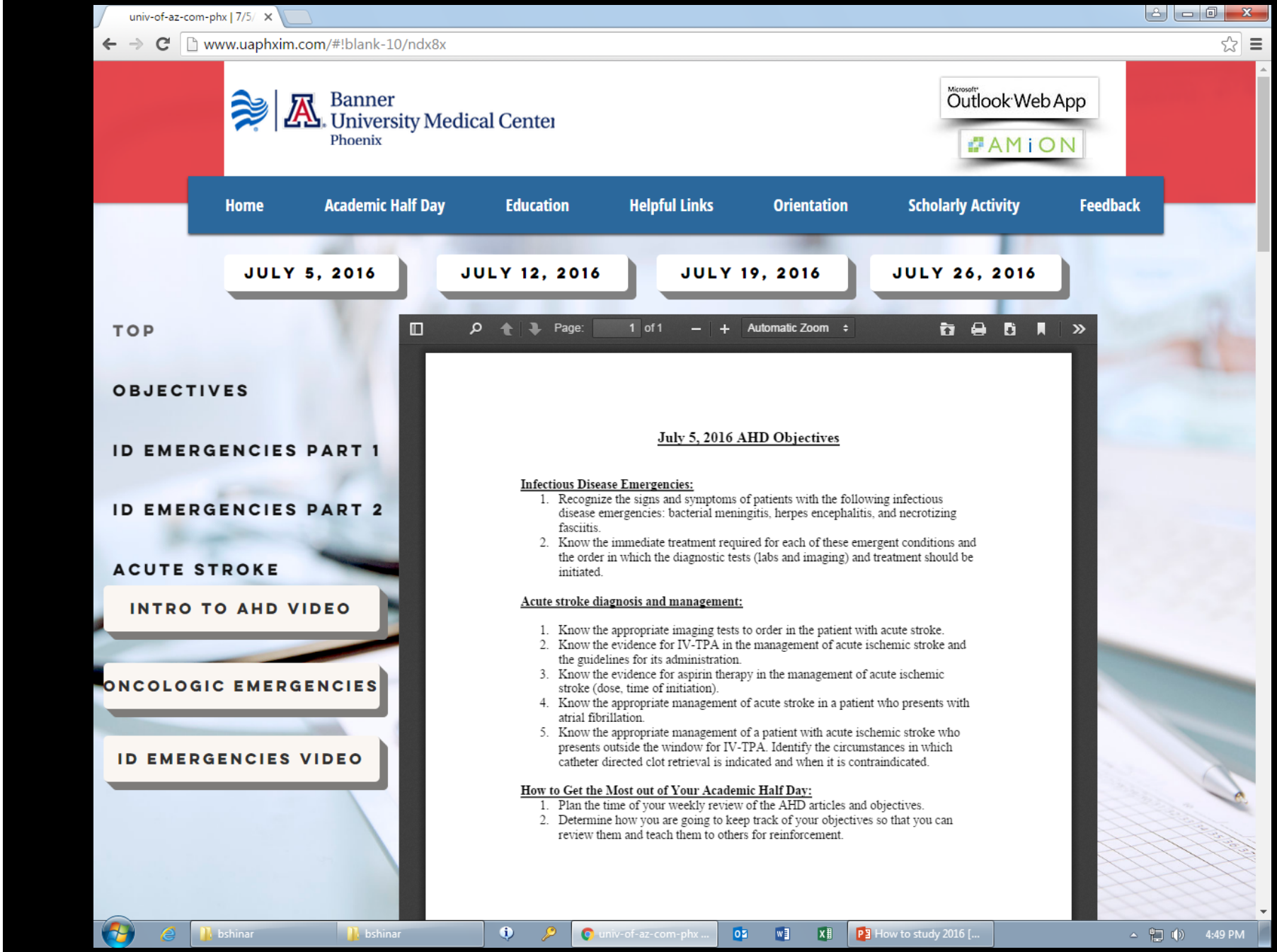
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July 5, 2016 AHD Objectives
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Acute stroke diagnosis and management:
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2. Determine how you are going to keep track of your objectives so that you can review them and teach them to others for reinforcement.
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Skin and Soft Tissue Infections

KALYANAKRISHNAN RAMAKRISHNAN, MD; ROBERT C. SALINAS, MD; and NELSON IVAN AGUDELO HIGUITA, MD
University of Oklahoma Health Sciences Center, Oklahoma City, Oklahoma

Skin and soft tissue infections result from microbial invasion of the skin and its supporting structures. Management is determined by the severity and location of the infection and by patient comorbidities. Infections can be classified as simple (uncomplicated) or complicated (necrotizing or nonnecrotizing), or as suppurative or nonsuppurative. Most community-acquired infections are caused by methicillin-resistant *Staphylococcus aureus* and beta-hemolytic streptococcus. Simple infections are usually monomicrobial and present with localized clinical findings. In contrast, complicated infections can be mono- or polymicrobial and may present with systemic inflammatory response syndrome. The diagnosis is based on clinical evaluation. Laboratory testing may be required to confirm an uncertain diagnosis, evaluate for deep infections or sepsis, determine the need for inpatient care, and evaluate and treat comorbidities. Initial antimicrobial choice is empiric, and in simple infections should cover *Staphylococcus* and *Streptococcus* species. Patients with complicated infections, including suspected necrotizing fasciitis and gangrene, require empiric polymicrobial antibiotic coverage, inpatient treatment, and surgical consultation for debridement. Superficial and small abscesses respond well to drainage and seldom require antibiotics. Immunocompromised patients require early treatment and antimicrobial coverage for possible atypical organisms. (*Am Fam Physician*. 2015;92(6):474-483. Copyright © 2015 American Academy of Family Physicians.)

The online version of this article includes supplemental content at http://www.aafp.org/afp.

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz Questions on page 441.

Author disclosure: No relevant financial affiliations.

▶ **Patient Information:** A handout on this topic, written by the authors of this article, is available at http://www.aafp.org/afp/2015/0915/p474-s1.html.

Skin and soft tissue infections (SSTIs) account for more than 14 million physician office visits each year in the United States, as well as emergency department visits and hospitalizations.[1] The greatest incidence is among persons 18 to 44 years of age, men, and blacks.[1,2] Community-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) accounts for 59% of SSTIs presenting to the emergency department.[3]

Classification

SSTIs are classified as simple (uncomplicated) or complicated (necrotizing or nonnecrotizing) and can involve the skin, subcutaneous fat, fascial layers, and musculotendinous structures.[4] SSTIs can be purulent or nonpurulent (mild, moderate, or severe).[5] To help stratify clinical interventions related infections[6] (*Figures 1 through 3*). Complicated infections extending into and involving the underlying deep tissues include deep abscesses, decubitus ulcers, necrotizing fasciitis, Fournier gangrene, and infections from human or animal bites[7] (*Figure 4*). These infections may present with features of systemic inflammatory response syndrome or sepsis, and, occasionally, ischemic necrosis. Perianal infections, diabetic foot infections, infections in patients with significant comorbidities, and infections from resistant pathogens also represent complicated infections.[8]

Risk Factors

Older age, cardiopulmonary or hepatorenal disease, diabetes mellitus, debility, immunosenescence or immunocompromise, obesity, peripheral arteriovenous or lymphatic


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Head and Neck Emergencies
Bacterial Meningitis, Encephalitis, Brain Abscess, Upper Airway Obstruction, and Jugular Septic Thrombophlebitis
Catherine J. Derber, MD*, Stephanie B. Troy, MD
KEYWORDS
• Meningitis • Encephalitis • Brain abscess • Epiglottitis • Ludwig angina • Lemierre syndrome
KEY POINTS
• Head and neck infectious disease emergencies can be rapidly fatal without prompt recognition and treatment.
• Empiric intravenous (IV) antibiotics, tailored to the patient's age and predisposing factors, should be initiated immediately in any patient with suspected bacterial meningitis.
• IV acyclovir should be started immediately in any patient with suspected encephalitis.
• Surgical intervention in addition to prompt initiation of antibiotics is often necessary for brain abscesses, epiglottitis, and Ludwig angina.
• A high index of suspicion is needed to diagnose epiglottitis, Ludwig's angina, and Lemierre's syndrome.
BACTERIAL MENINGITIS
Bacterial meningitis carries a high morbidity and mortality, requiring emergent intervention and treatment. The classic triad associated with community-acquired bacterial meningitis (fever, neck stiffness, and altered mental status) is uncommon, appearing in less than half of patients in 1 study, although 95% of patients had at least 2 of the following 4 symptoms: headaches, fever, neck stiffness, or altered mental status.[1] Headache is the most common presentation in several reviews.[1–3] Additional symptoms seen in patients with community-acquired meningitis include nausea and vomiting, photophobia, and rash (most commonly in the setting of meningococcal meningitis).[2,4] Physical examination findings associated with meningitis, such as Kernig's sign and Brudzinski's sign, are typically not helpful in the diagnosis of meningitis.[2] Given the lack of consistency of clinical features, a high index of suspicion is the cornerstone of diagnosis.
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Diagnosis of Acute Stroke

KENNETH S. YEW, MD, MPH, *Family Medicine of Albemarle, Charlottesville, Virginia*
ERIC M. CHENG, MD, MS, *University of California–Los Angeles, Los Angeles, California*

Stroke can be categorized as ischemic stroke, intracerebral hemorrhage, or subarachnoid hemorrhage. Awakening with or experiencing the abrupt onset of focal neurologic deficits is the hallmark of the diagnosis of ischemic stroke. The most common presenting symptoms of ischemic stroke are speech disturbance and weakness on one-half of the body. The most common conditions that can mimic a stroke are seizure, conversion disorder, migraine headache, and hypoglycemia. Taking a patient history and performing diagnostic studies will usually exclude stroke mimics. Neuroimaging is required to differentiate ischemic stroke from intracerebral hemorrhage, as well as to diagnose entities other than stroke. The choice of neuroimaging depends on availability of the method, the patient's eligibility for thrombolysis, and presence of contraindications. Subarachnoid hemorrhage presents most commonly with sudden onset of a severe headache, and noncontrast head computed tomography is the imaging test of choice. Cerebrospinal fluid inspection for bilirubin is recommended if subarachnoid hemorrhage is suspected in a patient with a normal computed tomography result. Public education about common presenting stroke symptoms may improve patient knowledge and clinical outcomes. (*Am Fam Physician*. 2015;91(8):528-536. Copyright © 2015 American Academy of Family Physicians.)

CME This clinical content conforms to AAFP criteria for continuing medical education (CME). See CME Quiz Questions on page 521.

Author disclosure: No relevant financial affiliations.

▶ Patient Information: A handout on this topic, written by the authors of this article, is available at http://www.aafp.org/afp/2015/0415/p528-s1.html.

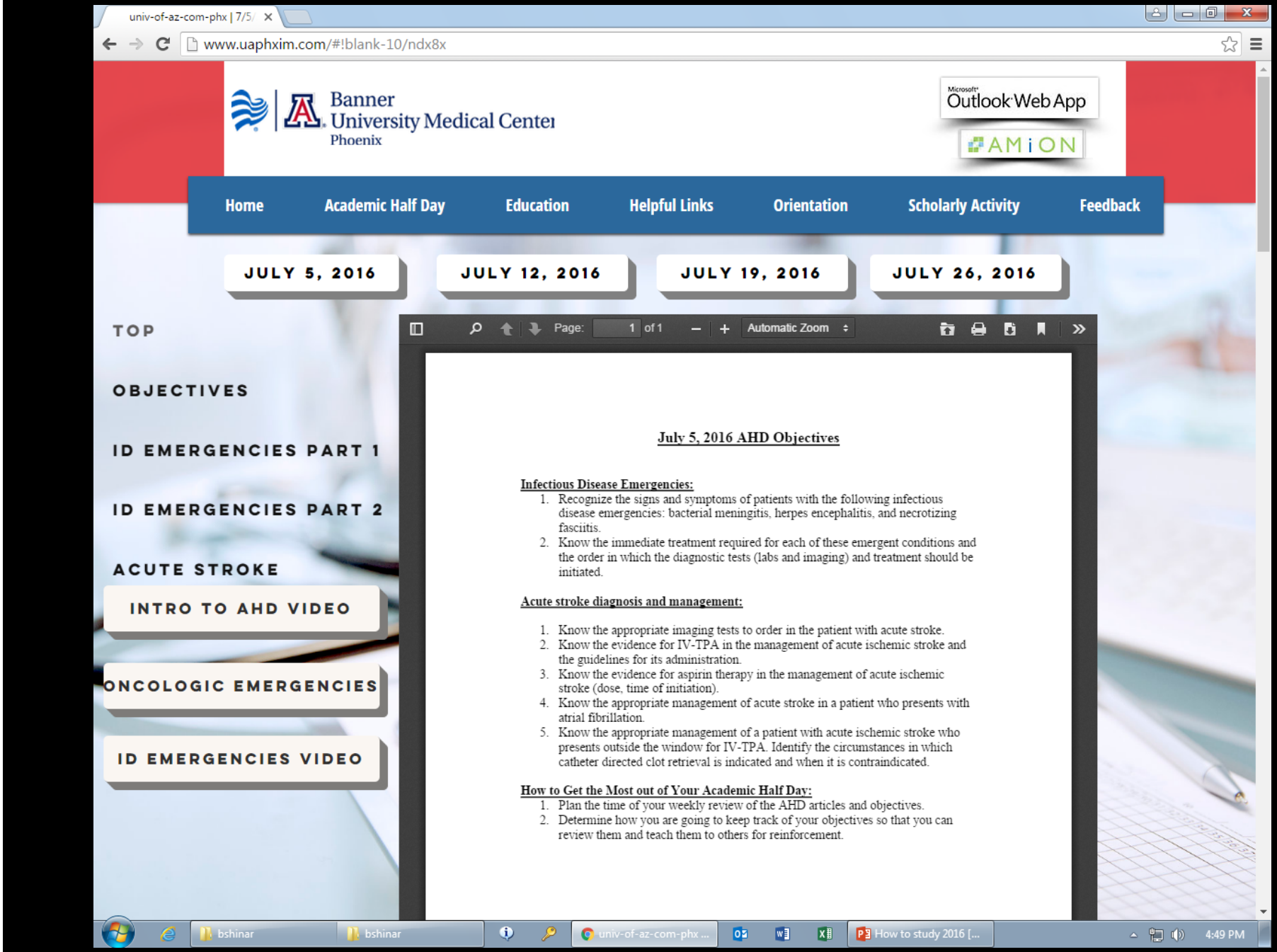
The symptoms of acute stroke can be misleading and misinterpreted by clinicians and patients. Family physicians are on the front line to recognize and manage acute cerebrovascular diseases. Rapid, accurate examination of persons with stroke symptoms can reduce disability and help prevent recurrences.

Classifying Stroke

Stroke can be classified by pathologic process and vascular distribution affected. Defining the overall pathologic process is critical for decisions on thrombolysis, antithrombotic therapy, and prognosis.

Risk Factors

Although there are many risk factors for stroke, such as age, family history, diabetes mellitus, chronic kidney disease, and sleep apnea, the major modifiable risk factors include hypertension, atrial fibrillation, smoking, symptomatic carotid artery disease, and sickle cell disease.[1] Physical inactivity; regular consumption of sweetened beverages; and low daily consumption of fish, fruits, or vegetables are also associated with an increased risk of stroke.[1] In women, current use of oral contraceptives, migraine with aura, the immediate postpartum period, and preeclampsia confer small absolute increases in risk of stroke.[1]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Housestaff Manual

EXCUSED ABSENCES:

- The ***only*** residents excused from this are on the following rotations:
  - BGSMC ICU
  - VA ICU
  - Vacation
  - **Residents must attend *every session in its entirety*.**
  - Any absence other than the above explained excuses must be cleared through Dr. Shinar.
  - An unexcused absence is a violation of professionalism.

ACADEMIC HALF DAY
MKSAP questions

- Each week in AHD, the session will start and end with board style questions based on the objectives and pre-reading.
- The conference will end with the same questions, with the opportunity to change your answer based on what you learned.
- We will be scoring your answers and keeping track of your scores quarterly.
- Your clicking also counts for your attendance.

AHD Objectives

- All residents are expected to read articles and do the objectives before each AHD
- If you have scored below 30th percentile on your ITE you must turn them in BEFORE AHD to Dr. Shinar AND Jane Sanborn by email
- Med-Peds Interns on Medicine are also required to turn them in to Dr. Holland and Jane Sanborn by email
- The ONLY times you are not required to turn them in are on ICU (BUMCP or VA) or vacation
- IF you do not turn them in ON TIME (reflected in House Staff Manual):
  - 1st time: Warning
  - 2nd time: One week extra sick call and must turn them in every week without regard to ICU or sick call
  - 3rd time: CCC committee referral for disciplinary consideration

How ITE scores have changed since AHD was implemented

	2012	2015
Cards	20	31
Endo	11	26
Gastro	39	65
Gen Med	63	64
H/0	6	40
ID	35	59
Renal	10	43
Neuro	55	53
Pulm	19	28
Rheum	3	17
Geri	46	52
Total	18	45

Dr. Bob Raschke

Dr. Edwin Yu

Top 8 Barriers (and solutions) to being the SMARTY pants you dream of...

Dr. Amandeep Khurana

Dr. Your Name Here!

The Top 8 Barriers

8. I'm just a bad test taker no matter how much I study.

“I’m a bad test taker.”

- **Test Anxiety or Attention**
  - Evaluation and treatment is available!
  - If this is NOT your problem, then its one of the following…
- **Poor Study Skills and Habits**
  - I’m a bad test taker = I don’t know the answers
  - Many subjects are hard to learn and take considerable effort with appropriate study strategies
- **Inflated self-assessment of knowledge, skill, or ability**
  - **Most students are very poor at “meta-cognition” or knowing what they know!**
  - **It is very hard to correct an inflated sense of knowledge…**
  - **The key indicator of this problem is that you don’t do well on the test!**

The Top 8 Barriers

7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

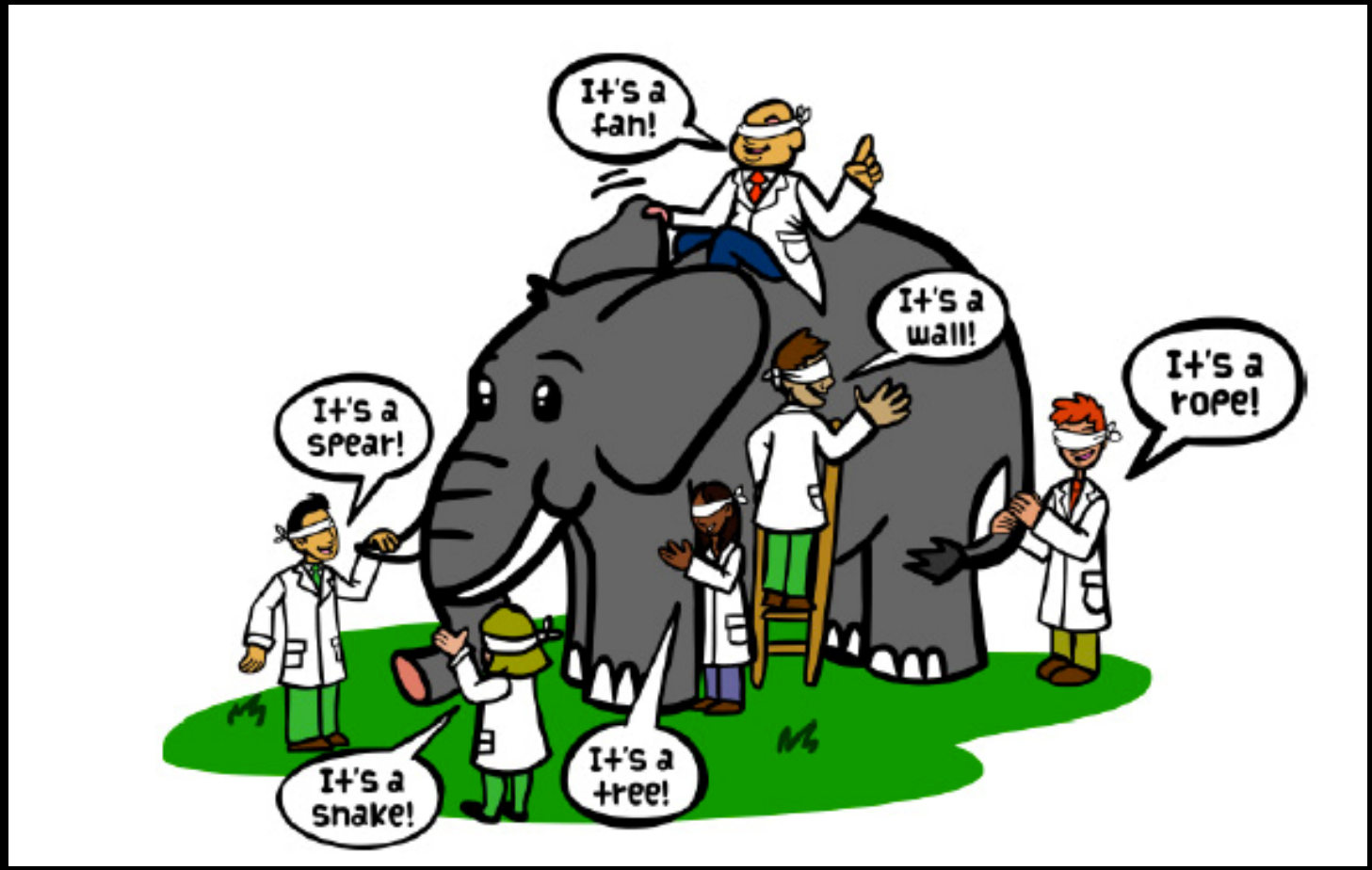
“My fellowship goals are more important than learning internal medicine.”

- Study and take an elective in your WEAKEST area.
- Fellowships are looking for well rounded fellows with excellent baseline GIM knowledge.
- Study it when you are on that rotation, be engaged and ask thoughtful questions.
- “Discipline is doing something you hate with the zeal and tenacity as if you loved it…”

The Top 8 Barriers

6. I learn best by doing questions rather than reading.
7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

“I learn best by doing questions rather than reading”



The Top 8 Barriers

5. The board exam is far away and I work best under pressure.
6. I learn best by doing questions rather than reading.
7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

“The Board Exam is far away and I work best under pressure”

- You always have a deadline!

- Weekly AHD articles/objectives
- Monthly MKSAP questions on electives (due 7 DAYS after finishing elective rotation)

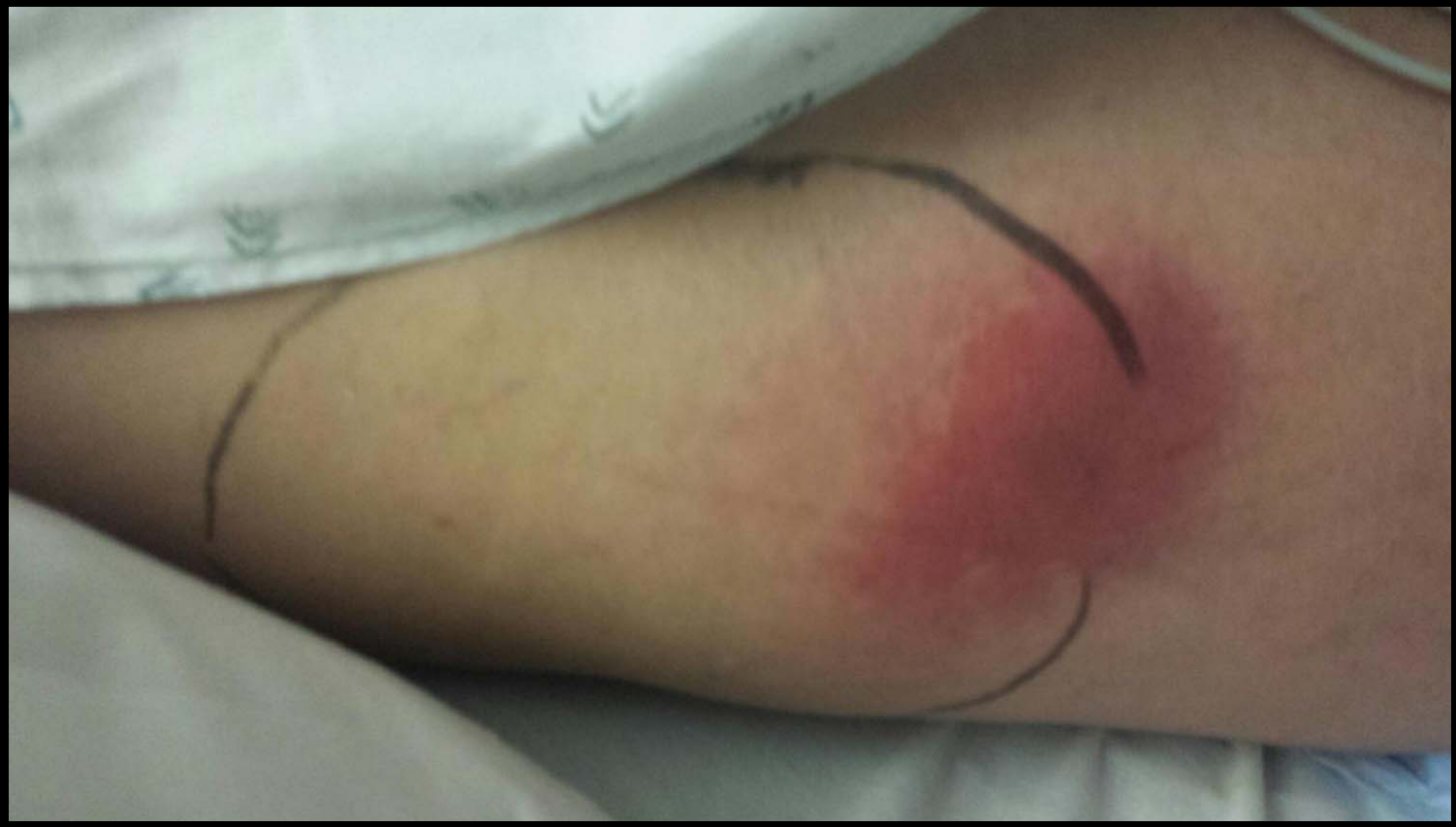
The Top 8 Barriers

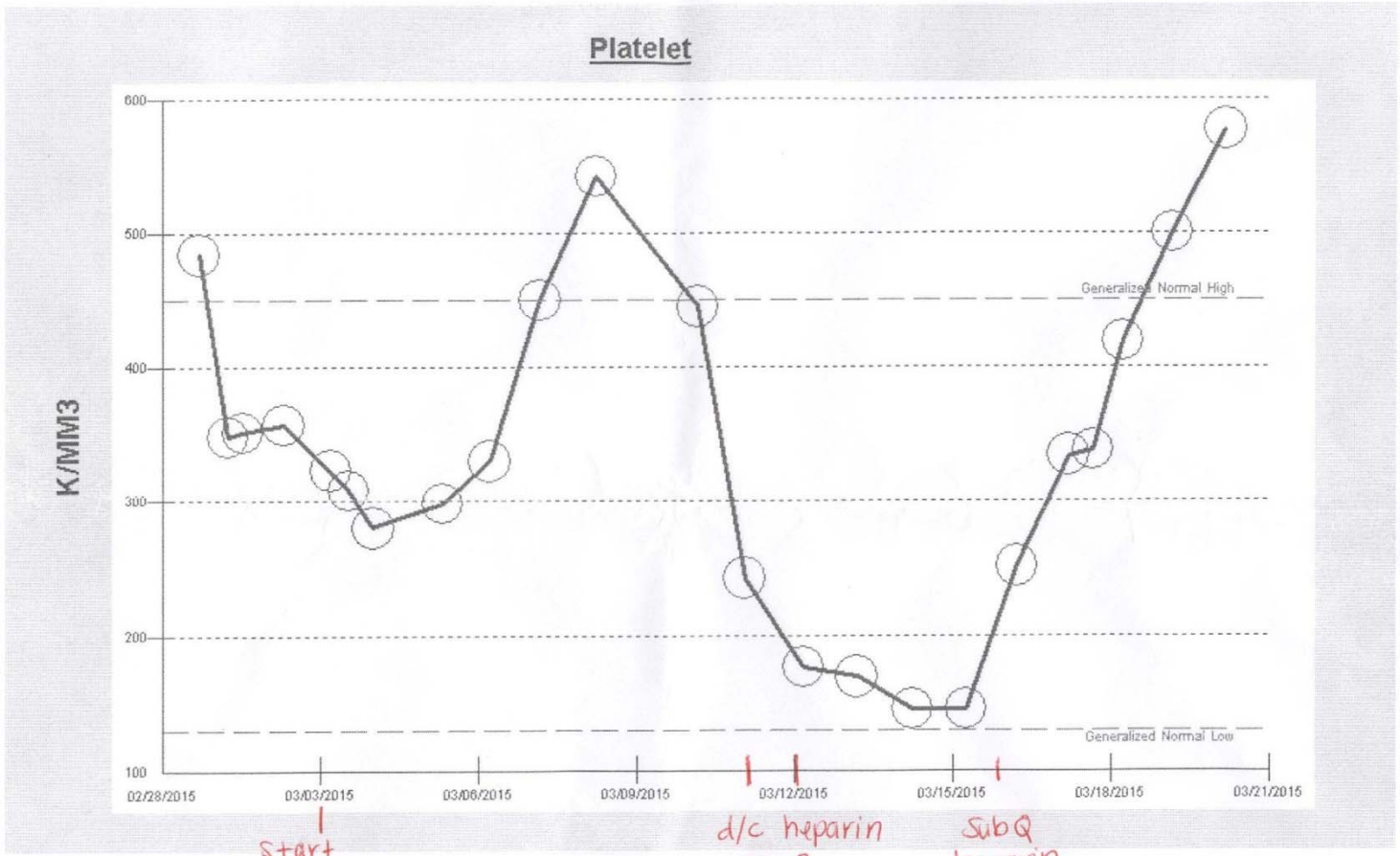
4. My medical knowledge is fine. (I don't know what I don't know).
5. The board exam is far away and I work best under pressure.
6. I learn best by doing questions rather than reading.
7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

“The faculty haven’t said anything bad about my medical knowledge, it must be fine.”

Board Pass Calculator

http://www.r-calc.com/administrator/calculatorPreview.aspx?isGrid=0&mobile=0&isTemp=0&calculator_id=de409368-643f-4f71-b96e-b040cb7478bf

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The Top 8 Barriers

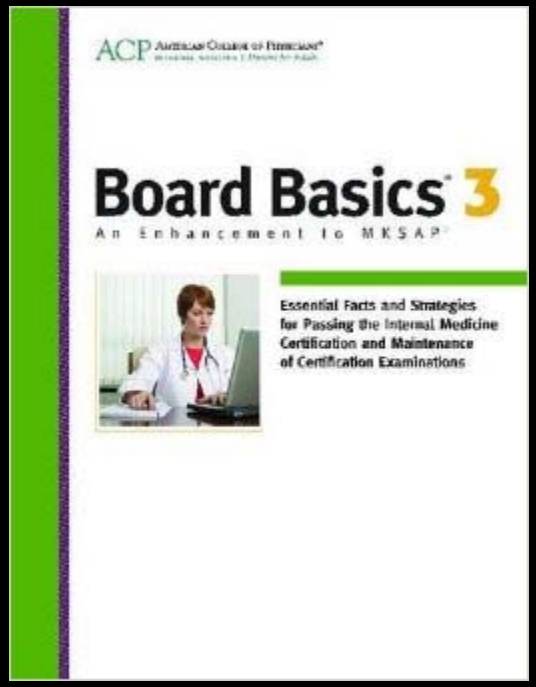
3. I don't know how to make the knowledge stick.
4. My medical knowledge is fine. (I don't know what I don't know).
5. The board exam is far away and I work best under pressure.
6. I learn best by doing questions rather than reading.
7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

“I don’t know how to make the knowledge stick.”

- Make your reading active!
  - *What do I already know about this topic?*
  - *What should I get out of this? (objectives)*
- Apply it- anything!
- Teach it!

- Take notes!
- Study your notes!
  - Before the end of the month test…
  - Before the ITE exam…

Review and grow your notes



The Top 8 Barriers

2. There is too much to read and I am not sure where to start or how to get organized.
3. I don't know how to make the knowledge stick.
4. My medical knowledge is fine. (I don't know what I don't know).
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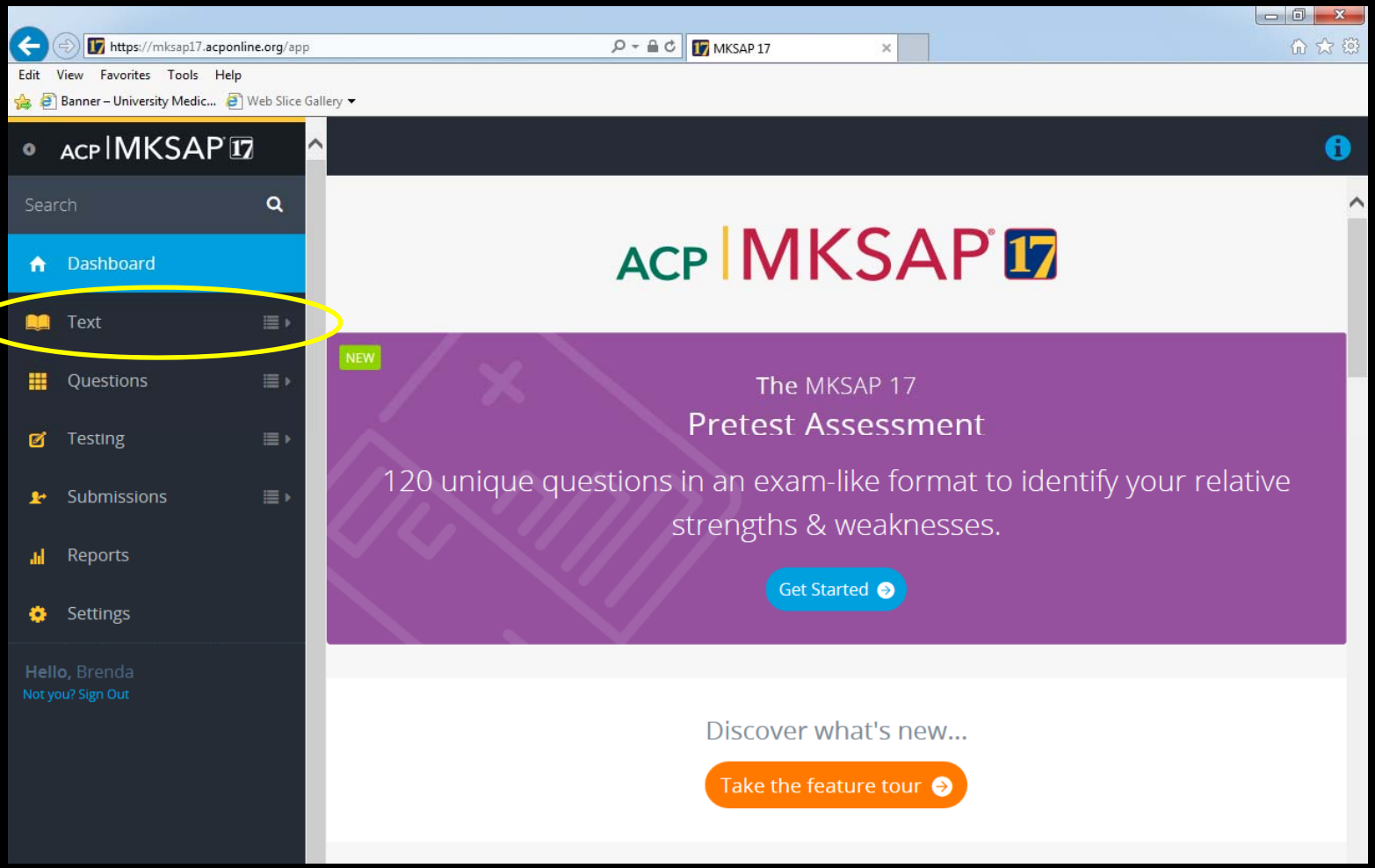
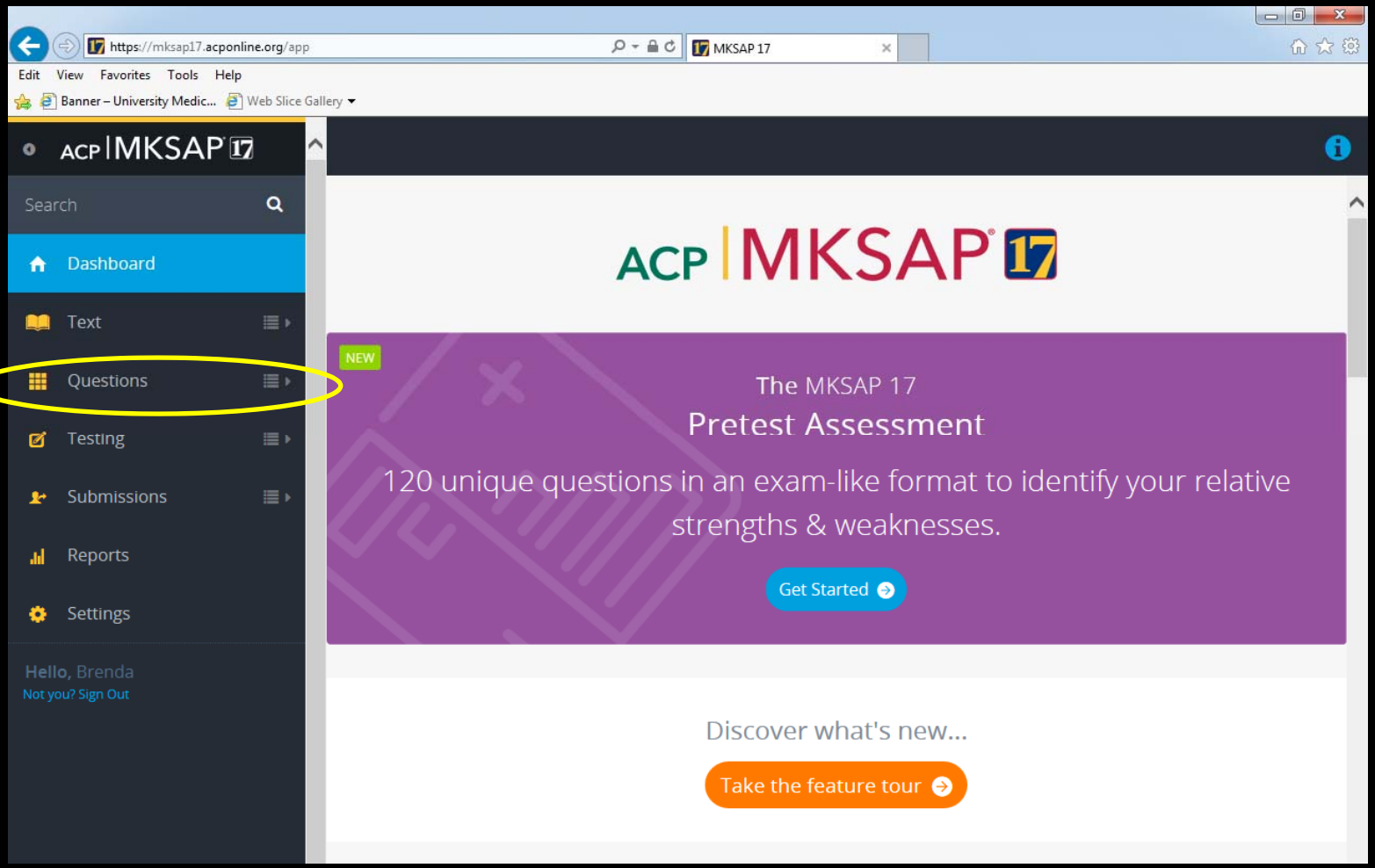
“There is too much to read and I don’t know how to get organized”

Call Months	Non-Call Months
Your patients- Read whatever is handy/answers your ?. What else do you need to consider in the differential? Does this fit the typical illness script? Does our treatment match the current recommendations? If not, why?	Your patients- •MKSAP content for that topic •Daily discussions with the subspecialty attendings
Other: am report prep (seniors), teaching topics on rounds **	Rotation assignments
	Clinic articles
Academic ½ day weekly readings – What do you already know about the topic? What is the minimum that should you know (objectives)?	AHD readings: Objectives due?
Journal Club Grand Rounds Articles	Journal Club Grand Rounds Articles

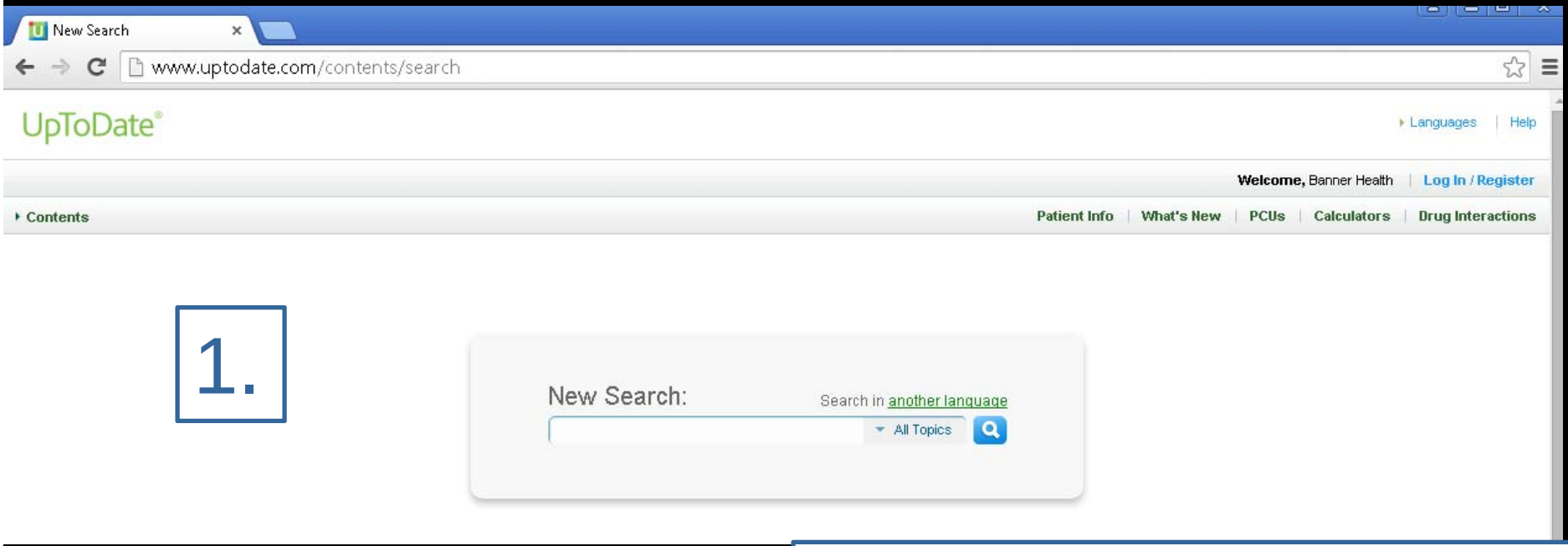
Read the content



Answer 100 Questions →Submit



Read about your patients



1.

2. Review referenced studies

3. Look up your own search

Academic Half Day

- Review the objectives
- Prepare answers to the objectives by reading the articles and any supplemental reading
- Attend conference and listen actively
- Review and talk about in your daily work
- Return to the objectives, articles, slides, and video as needed
- Review and talk about in your daily work

My Study Calendar

	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
My rotation												
AHD topic												

The Top 8 Barriers

1. Patient care counts as studying and I just worked a 12+ hour day.
2. There is too much to read and I am not sure where to start or how to get organized.
3. I don't know how to make the knowledge stick.
4. My medical knowledge is fine. (I don't know what I don't know).
5. The board exam is far away and I work best under pressure.
6. I learn best by doing questions rather than reading.
7. My fellowship goals are more important than learning internal medicine.
8. I'm just a bad test taker no matter how much I study.

“Patient care counts as studying and I just worked a 12+ hour day”

- We know!!
- Find little islands of time in your day
- Have something handy to read/study at all times
- Use it and refer to it

- Slow and steady WINS the race!
- You ALWAYS have time for what is important to you.

Impressions

- About you
- About the program
- About our profession