



# Standing Room Only

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How to *Vitalize Morning Report*





# How We Used to do MR



(Video)





# How we now do MR

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(Video)



What do YOU value the most?  
Why do YOU want to go to Morning Report?  
(audience participation)

# Historical Context: House Staff

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## OFFENSE/DEFENSE-

Residents would be scrutinized in the morning post call for their decisions made overnight.

All housestaff teams would gather with PD/ Chair

The attending would review admissions

Would occur every day including weekends.

# Why Things Changed

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Patients are ever more complex and the growth of medical knowledge and data is growing exponentially

Overnight teams are now supervised by in-house attendings and are supposed to receive education while on night float

Duty hours have been implemented (more programs are switching from 24 hr call to a night float system)

Trainees have different learning styles (visual, auditory, read/write, kinesthetic)

How many programs do not have  
overnight attending support?  
(audience response)

# First Breakout

What are your program goals for  
Morning Report?  
(mini groups on WHY)

Summary of Small Group  
Discussions  
(speaker from each group)

# Goals and Objectives of a Morning Report

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Education and knowledge (sponge vs search)

Problem solving

Data gathering skills

“Active listening” training

Evaluate residents: formal and informal; card flip; evaluating the H&P during that same case

Quality evaluation

Indirect Medical Training: Ethical, coding, financial, high value care, cost effectiveness

FREE BREAKFAST and social interaction

Opportunity to sign out

# What is Morning Report like at your institution (How)

- Structure
- Content
- Leaders and Participants
- Expectations

(Small Group discussions broken up by program size)

Summary of Small Group  
Discussions  
(speaker from each group)

# Format and Setting

- Structure and Frequency:

- 3x/week
- Weekends

- Timing

- Mornings
- Lunch

- Duration

- 30 min, 1 hour

- Participants

- Interns
- Residents
- Attendings
- Non-Service personnel

- Leadership

- Faculty
- Chiefs
- Residents

- Atmosphere/Tone

- Intimidating or Open

- Content

- Bread and Butter
- Exotics

- Outpatient vs Inpatient

- IM curriculum

- Librarian/Lit Review

- Ethics/ Research

# Content- Where do you get your material?

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- Case Based
  - New Cases
  - Prior Admissions/Prepared Topics
- MKSAP questions
- Journal Club
- NEJM interactive/scripted cases
- Mini lectures
- Board Review
- Bedside Teaching

# Presentation Style

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- Question/Answer/Interactive
- Full disclosure of all available evidence vs holding back
- $\frac{2}{3}$  socratic and  $\frac{1}{3}$  didactic
- Grow medical knowledge and skills
- Formal instruction on making effective presentations
- Mentoring

# Data Collection

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Sign in/attendance

Summary to housestaff via email

Recording of presentations

Quizzes

Feedback from residents

How effective is your program in  
achieving your goals?

What would you change?

What are your Strengths?

Pitfalls?

(small group breakout)

# Breakout- Effectiveness

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How are these structures/ systems working for your program?

What are the advantages?

What are the pitfalls?

# Feedback from Our Residents

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- More board review, including MKSAP questions
- More specialist presence (e.g. cardiology, heme/ onc etc)
- More interactivity from both faculty & residents
- More variety of topics
- Graduated content (increase in complexity as the year goes by)
- More efficient use of time
- Shorter time frame
- Did not like unsolved cases. Wanted daily updates.
- Structured teaching points & disseminate pearls via email/ social media
- Repeal “stick” system for attendance
- Free food

# Our Changes



# Timing and Length

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Originally an hour long starting at 8 am, and rounds start at 9.

Residents wanted more time in the morning to do their work

Some proposed noon reports

Cons of noon reports: attendance closely correlated with if there was free lunch. Teams would still be rounding. Other meetings usually scheduled at noon

We shrank it to 45 minutes, starting at 8:15

# Case Selection

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Old system: overnight admissions

Cons: may not have diagnosis or hospital course

New system: residents select interesting resolved cases

Allows residents to select a case they would enjoy presenting

Does not have to be a Zebra

Does need lots of high yield teaching points

# Preparation and Planning

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Monthly Didactic Schedule sent out a month ahead

Chiefs review and select from among possible cases at least one week prior

No more scribing the case during presentation

Key information are pre-populated in standard PPT format, e.g. HPI, PMH, Meds, Exam, Labs, Studies, Hospital Course. Due 3 Days prior.

Residents encouraged to add slides on at least one focus of teaching

Chiefs Insert our own teaching slides

In person rehearsal at least 1 day prior

# Presentation Style

Ensure appropriate pauses for resident engagement

Avoid reading the items easily obtained from the PPT itself

Running through the imaging and labwork as a group

Asking interns to read a CXR or a senior to read an ECG

Ensuring we have appropriate pauses for building a differential

# Avoiding the Outliers and Creating a Culture

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Reduce workload for the presenter for each MR by using a template PPT

Early in the year, the Chiefs add the teaching point; transitioning to the Resident collecting this teaching point later in the year

Starting with those with lower workloads (consult/elective months) and transitioning to by the end of the year the GIM service residents and interns presenting

Establishing strong examples of exemplary presentations (Chiefs presenting the first of the Morning Reports in this structure)

Allows for progression of cases; starting simple and advancing beyond that

# Bringing In the Experts

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Invite specialists, both attendings and fellows, pertinent to the case being discussed.

Allows the opportunity for those with the most advanced applicable understanding of the cases to interact with the case while provide meaningful analysis and alternatives.

Allows residents a view into the “why” of different medical decisions from the expert’s mouth (giving insight not available below that level of training)

Allows residents to interact with and build trust in their subspecialty colleagues, whilst generate interest in these fields

# Engaging the Residents

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## Typical weekly schedule for Morning Report/Conference

Mondays: Chair's Report

Tuesday and Thursday: Cases prepared by residents with additional learning points given by Chief Residents

Wednesday and Friday: Board Review based on monthly theme (e.g ID in January), typically using MKSAP questions and rehearsed cases.

Other: Small group skills and case scenario simulations, Physical Exam day, M&M's, QI series, and "Card Flip."

# SIM Lab Project

## Simulated Multidisciplinary Pre-Code Scenarios

E.g. Refractory hypoxia in COPD, refractory hypoglycemia

Rapid response faculty, Nursing students, Respiratory therapy students and faculty

Pulmonary fellow and attending debriefs on standardized areas of focus

Leadership, team communication, etc

Pre and post quizzes to reinforce learning

Simulated ACLS Codes with debrief and MOC Codes in-situ on the wards

Simulated Skills sessions: Central lines, paracentesis, etc

# Attendance Policies

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75% expected for residents on electives

40% expected for inpatient residents, except ICU and Cardiology

Sign in with TimeStation iPad

Residents expected to contact Chiefs prior to being absent

Elective residents with unexcused absence expected to teach at Morning Report

Building a culture of engagement and participation (accountability system starting with attendings and seniors acting as examples for attendance)

# “Greasing the Wheels”

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Maintenance of the quality of the morning report and regular self-evaluation

Leveraging the work of your prior Chiefs and faculty- google drive, Blackboard, recording and reviewing

Re-using questions from available resources (MKSAP, UWorld, etc)

Avoiding re-inventing the wheel

# Our Results



# Attendance Record

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# Survey Response Results

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42 out of 48 residents responded to 12 question survey

Has Morning Report improved from last year?

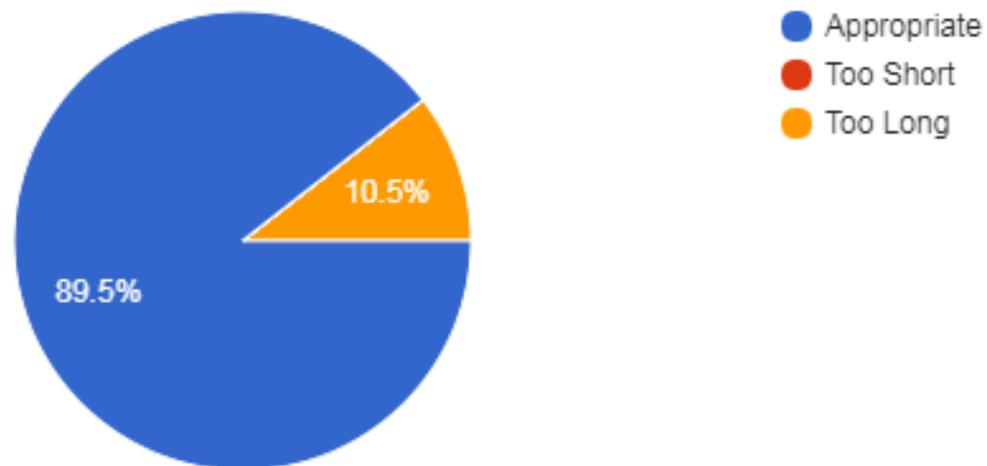
79% of respondents said yes.

16% said it's the same.

5% said it's worse.

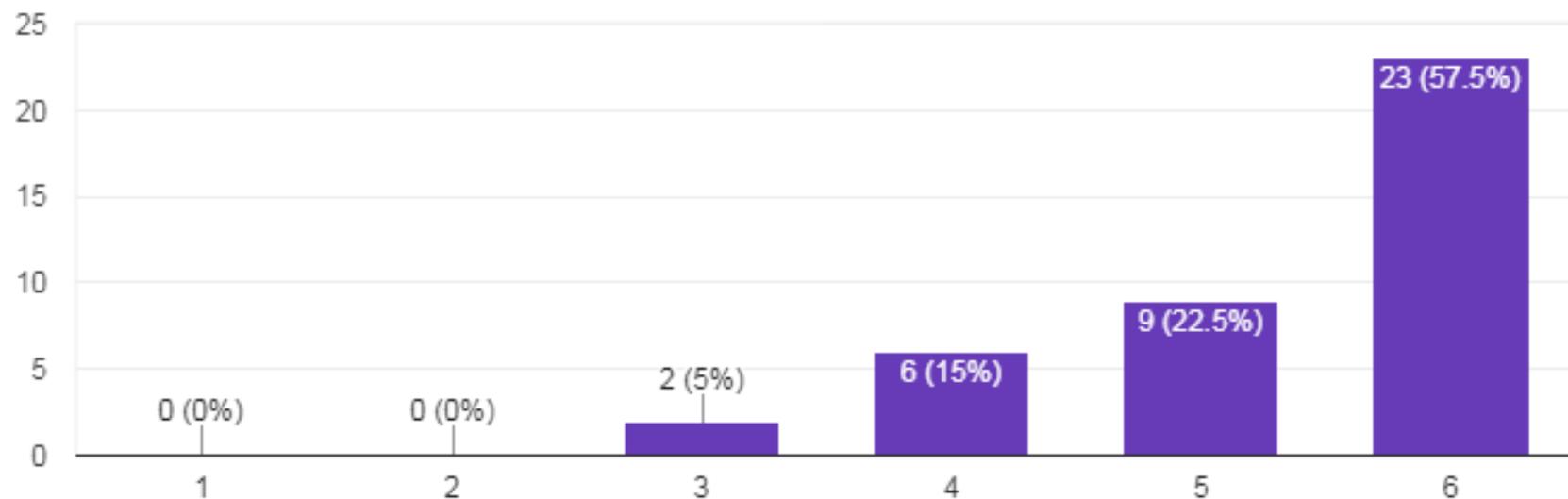
## What do you think of the amount of time spent (45 min) in MR?

38 responses



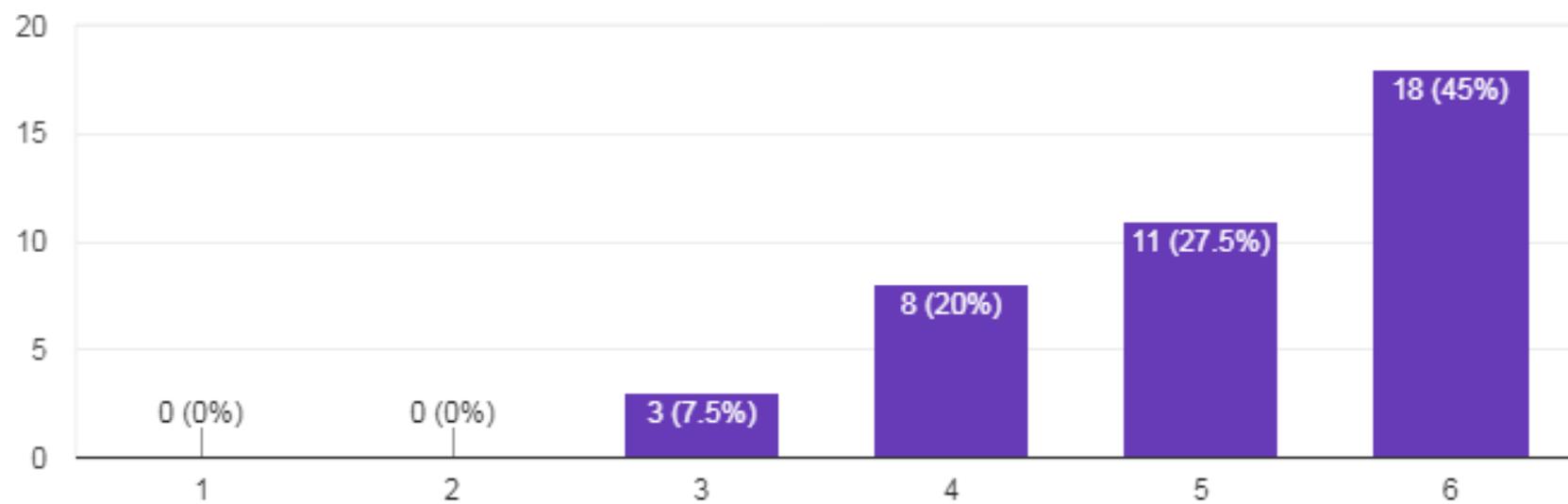
## How productive is having the "specialist" present in Morning Report (eg Heme/Onc attending)

40 responses



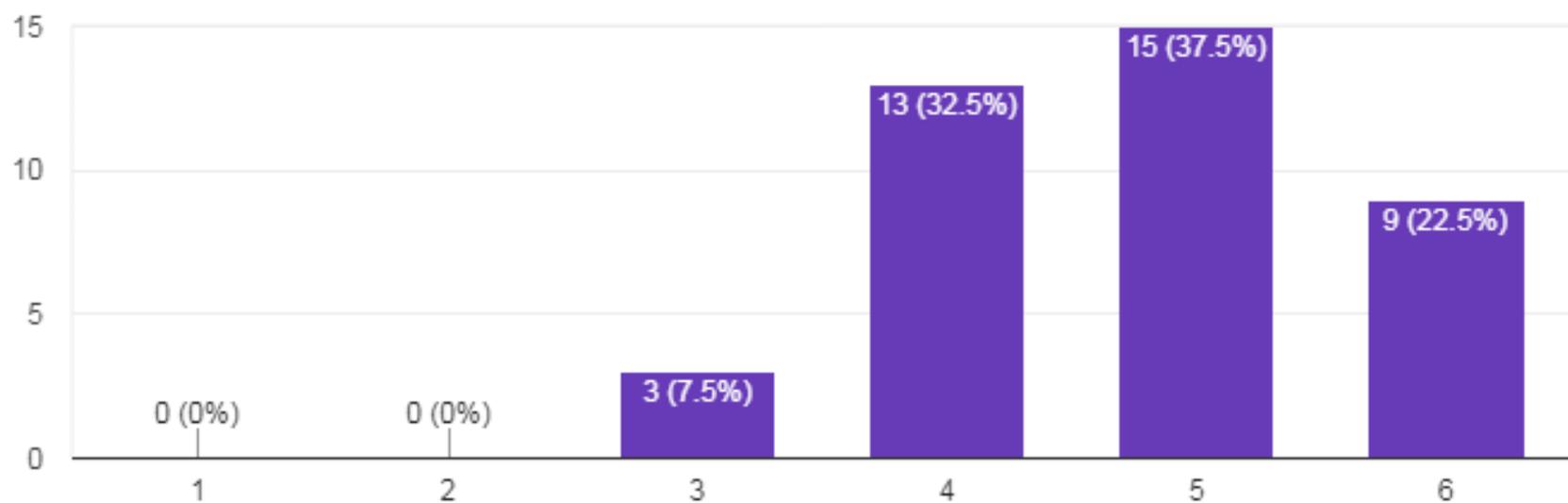
## How useful is it in presenting a prepared/resolved case? (vs. overnight or unresolved case)

40 responses

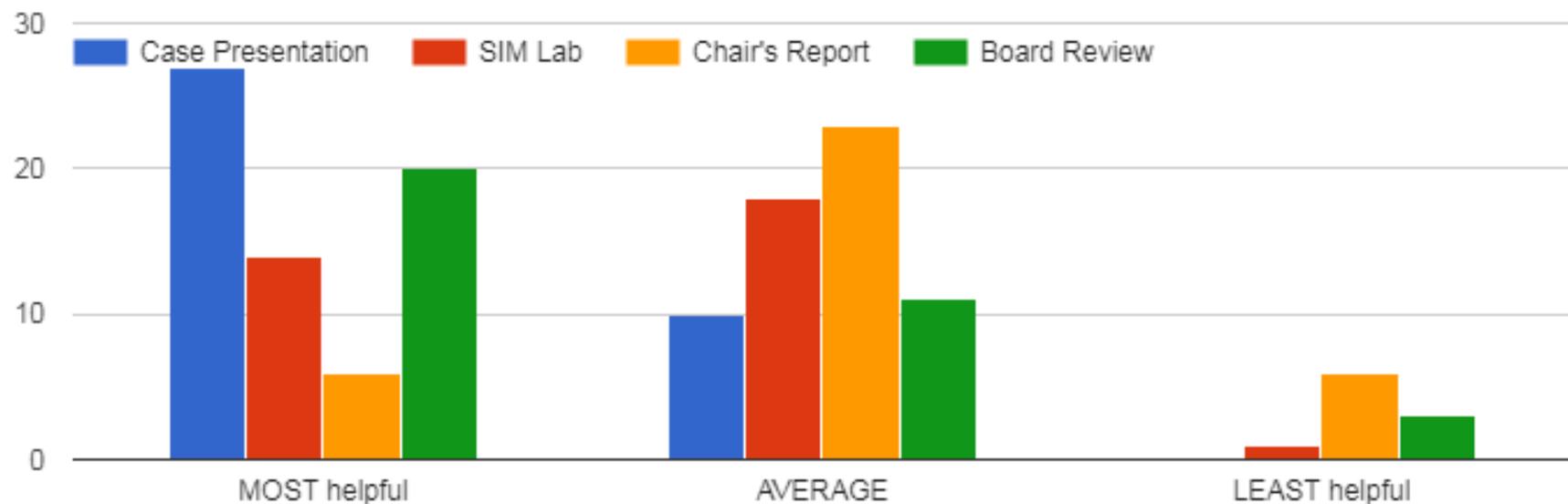


## How do you feel about the variety of Morning Report?

40 responses

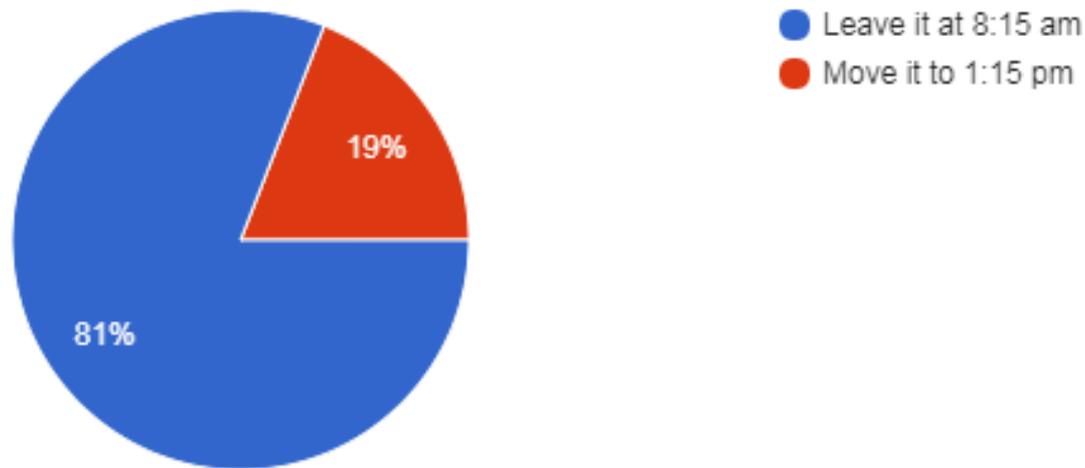


## Which Morning Report format(s) did you find most helpful?



## What do you think about moving Morning Report to 1:15 pm?

42 responses



# Where We Hit Roadblocks (Pitfalls)

Specialists hijacking MR to educate our residents

Leaving too much time for questions-- may lead you in a direction that may not be productive

Individuals missing a whole section because they were in a non-MR rotation

Technical difficulties- if the computer goes down, what then???

Skill differences in resident presenters

Workload for the Chiefs- how much of our time do we dedicate to this one part of our job?

Time requirements for coaching residents

# A Challenge to YOU

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How will you incorporate this knowledge?  
How will you build on our strengths, and avoid our  
pittfalls?

# PEARLS

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Craft a curriculum and rotate the schedule

Have clear and specific expectations for speakers and participants

Record and distribute your work

Review and reiterate at other educational meetings

Notify speakers and faculty early and often

Prime presenters before their day, and give direct and specific feedback after

Have clear and memorable “take away” points for each presentation

Keep in close touch with the residents, faculty, and each other