



CHATHAM UNIVERSITY
PHYSICIAN ASSISTANT STUDIES

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Preceptor Handbook

Preceptor Handbook

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INTRODUCTION

Introduction to the University

Chatham University was founded in 1869 and is located on 32 acres in the Shadyside area of Pittsburgh. Its liberal arts education offers curriculum in the sciences, humanities, fine and performing arts, professional programs, environmental studies, international studies, and global policy studies. Chatham is the home of the Rachel Carson Institute.

Chatham University offers the following Master degree programs to men and women in the health sciences: counseling psychology, nursing, physical therapy, occupational therapy, athletic training, and physician assistant studies. Doctoral programs are also available for the psychology, nursing, physical therapy and occupational therapy.

Chatham University is accredited by the Commission on Institutions of Higher Education of the Middle States Association of Colleges and Secondary Schools, the American Chemical Society, the Pennsylvania Department of Education Teacher Certification Program, the Accreditation Council for Occupational Therapy Education, the American Physical Therapy Association and ARC-PA (Accreditation Review Commission on Education for the Physician Assistant, Inc.).

Introduction to the Program

The Master of Physician Assistant Studies (MPAS) Program at Chatham University provides academic and clinical training that prepares its graduates to be certified and licensed to practice as extenders to the practicing physician, especially the primary care physician, in a competent and reliable manner.

Vision and Mission Statements

To strive for excellence in physician assistant education whose graduates are known as outstanding clinicians in the community and leaders in the profession trained by faculty who are recognized for developing and researching innovative curricular methods.

The Chatham University MPAS Program is dedicated to producing knowledgeable, compassionate, ethical, and clinically skillful graduates that are ready to provide healthcare services to all persons without exclusion and who are willing to become the future leaders and educators of the profession. This is accomplished by:

- Providing a student-centered curriculum which promotes self-directed and lifelong learning as well as professionalism and service;
- Educating competent physician assistants to practice as primary care providers to all populations;
- Contributing to the advancement of knowledge in medicine and physician assistant education;
- Encouraging students to serve local, national, and international communities through active involvement in service-oriented programs for medically underserved populations; and
- Promoting participation in professional organizations and the education of future PAs.

INTRODUCTION (continued)

Accreditation

The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) has granted **Accreditation-Continued** status to the **Physician Assistant Program** sponsored by **Chatham University**. Accreditation-Continued is an accreditation status granted when a currently accredited program remains in compliance with the ARC-PA *Standards*.

Accreditation remains in effect until the program closes or withdraws from the accreditation process or until accreditation is withdrawn for failure to comply with the *Standards*. The approximate date for the next validation review of the program by the ARC-PA will be **March 2024**. The review date is contingent upon continued compliance with the Accreditation *Standards* and ARC-PA policy.

Curriculum

The curriculum is a 24-month (85 credits) professional course of study leading to the Master of Physician Assistant Studies (MPAS) degree. Basic medical sciences, research, clinical methods, and clinical experiences are integrated from the beginning of the program and continued throughout the course of study.

The ultimate goal of Chatham's Physician Assistant Studies Program is to produce physician assistants capable of providing primary medical care in an ethical, legal, safe, and caring manner. To achieve this goal, students must acquire knowledge and the ability to use that knowledge in the practice of medicine. Physician Assistant students must repeatedly apply their knowledge in order to increase its usefulness. They must be able to reason effectively and to retrieve and apply their knowledge appropriately in the care of patients. They must acquire self-directed learning skills in order to keep their knowledge current. Students can learn what is acceptable and appropriate at the time of learning, but as the body of skills, procedures, and knowledge is ever growing and changing, the students must apply the ability to expand their education after leaving school. It is also important that the students develop the ability to interact effectively with patients and other healthcare professionals. They need to understand themselves and others in order to deal with all aspects of the patient's problems.

Chatham University utilizes hybrid model of Problem-Based Learning, lecture, and on-line activity that challenges students to be self-directed and prepares students for the evidence-based, problem-oriented world of clinical medicine. Through actual patient cases, students develop learning issues, research topics using the most up to date resources, work in teams and receive feedback on knowledge base as well as professionalism to prepare them for primary care, problem-focused clinical practice.

PRECEPTOR RESPONSIBILITIES

1. Orient the student to the work environment including site safety information and evacuation plans.
2. Make known your expectations of the student's role for the rotation. You can use our "Clinical Objectives" as a reference. Please discuss student's use of smart phones for researching learning issues.
3. Provide **hands-on learning** under your **direct supervision**. It is expected that students participate in all aspects of patient care in the **outpatient, inpatient and long-term care settings**. Depending on the type of rotation, this may also include hospital rounds, emergency/urgent care and assisting in the operating room.
4. Facilitate the student's learning of your specialty by listening to patient presentations, questioning the student and providing feedback. Challenge the student to identify areas of insufficient knowledge and to use this as an impetus for additional learning.
5. Provide at least **32-40 hours per week** of work for the student (an equivalent of **at least 160 hours total** for the entire 5-week rotation), with a maximum of 60 hours per week, including on-call hours. You set the hours for the student, within these parameters, as you feel appropriate.
6. When available, feel free to share resources with our students (books, journal articles, etc.) and provide opportunities to enhance professional development (grand rounds, team meetings, etc.).
7. We ask that if you are not available at any time you are scheduled to precept to let us know immediately so we can reassign the student(s) to another site.
8. If there are any changes in the precepting team, please let us know so we can update their names in our database.
9. If there are any changes in the facilities that the precepting team works at, please let us know so the information can be updated in our database.
10. The program should not rely primarily on resident physicians for didactic or clinical instruction.
11. All instructional faculty serving as supervised clinical practice experience preceptors must hold a valid license that allows them to practice at the clinical site.
12. Physicians should be either **Board Certified** for the specified area of instruction or **have worked in their specialty for five or more years**.
13. Students must not substitute for clinical or administrative staff during supervised clinical practical experiences.
14. Evaluate the student in a timely fashion.

CLINICAL PERFORMANCE OBJECTIVES

Clinical Experience (CE) Performance Objectives

- **Family Practice**
- **Internal Medicine**
- **Emergency Medicine**
- **Pediatrics**
- **Psychiatry/Behavioral Medicine**
- **Women's Health**
- **Surgery**
- **Medical Subspecialty Elective**
- **Surgical Subspecialty Elective**
- **Professional Growth**

Family Practice Clinical Performance Objectives

Upon completion of the **Family Practice Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Utilizing all available information sources (patient, family, community, old records), student will elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- C. Perform and document a complete and focused physical examination, appropriate for the patient's age, to include the following:
 1. an organized head-to-toe approach
 2. using proper technique
 3. selecting the sections of the physical exam pertinent to the patient's complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
- D. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
 1. the most likely diagnoses, based on history and physical exam data
 2. the most common entities
 3. the most severe and/or life-threatening entities
- E. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- F. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
 1. rationale for utilizing each drug, including mechanism of action
 2. indications, contraindications and adverse reactions
 3. delivery method
 4. potential drug-drug interactions
 5. cost-effectiveness
 6. documented patient education regarding side effects and adherence issues

Family Practice Clinical Performance Objectives (continued)

- G. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
1. behavioral and psychosocial interventions
 2. referrals to other health care providers
 3. referrals to community resources
 4. utilization of family resources
 5. plans for follow-up care
- H. Provide and record pertinent patient education regarding disease prevention and health maintenance, which is clearly explained to the patient and checked for understanding, to include:
1. nutrition
 2. accident and violence prevention (e.g. seat belts, helmets, screening for domestic violence)
 3. physical activity/exercise
 4. pertinent risk factors, including occupation, environment, tobacco, alcohol, other drugs and genetic factors
 5. warning signs/symptoms of diseases
 6. plan for age-appropriate screening and periodic health assessment
- I. Provide patient counseling to include:
1. adjustment to states of health and disease as related to ADLs, sexuality, relationships, death and dying
 2. consideration of patient's health beliefs and practices, religious/spiritual beliefs and lifestyle choices
 3. consideration of socioeconomic, racial and ethnic factors
 4. family issues
 5. occupational and leisure issues
 6. anticipatory guidance appropriate to patient's age
- J. Monitor patients' progress over time, to include:
1. reassessment of subjective and objective data
 2. reconsideration of differential diagnosis, as needed
 3. modification of management plan, based on patient's health status and adherence issues
- K. Chart progress notes following the SOAP format to include:
1. subjective data
 2. objective data
 3. assessment
 4. plan
- L. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.

Family Practice Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following symptoms and diagnoses:

PROBLEM LIST

SYMPTOMS

Fatigue and Weakness
 Fever
 Weight loss
 Syncope
 Headache
 Vertigo/dizziness
 Angina
 Chest Pain
 Obesity
 Constipation
 Diarrhea
 Dyspepsia
 Low back pain
 Shoulder, neck, arm pain
 Joint pain/arthritis
 Abdominal pain
 Amenorrhea
 Cough
 Ear Pain
 Nasal congestion/rhinorrhea
 Sore throat
 Vision changes
 Rash
 Pruritus

DIAGNOSES

Cardiovascular

Hypertension
 Congestive Heart Failure
 Valvular Heart Disease
 Coronary artery disease
 Myocardial infarction
 Pericardial disease
 Peripheral vascular diseases
 Thromboembolism
 Arrhythmias
 Cardiomyopathies
 Congenital Heart Defects
 Dyslipidemias
 Edema

DIAGNOSES (cont.)

Respiratory

Asthma
 COPD (emphysema, chronic bronchitis)
 Upper Respiratory Infections
 Influenza
 Pneumonia
 Tuberculosis
 Acute Bronchitis
 Obstructive Sleep Apnea
 Acute Respiratory Distress (Identification)

Ear /Nose/Throat

Sinusitis
 Otitis externa/media
 Epistaxis
 Cerumen Impaction

Endocrine

Goiter
 Hypo/Hyperthyroidism

Hematology/Oncology

Anemia
 Lung Cancer
 Colon Cancer
 Breast Cancer
 Bleeding disorders
 Platelet Disorders
 Hypercoagulable states

Infectious Disease

Sexually transmitted diseases
 HIV infection
 Vaginitis & Cervicitis
 Lyme Disease

Family Practice Clinical Performance Objectives (continued)**PROBLEM LIST
DIAGNOSES (cont.)****Gastroenterology**

Pancreatitis
 Hepatitis
 GERD/PUD
 Irritable Bowel Syndrome
 Inflammatory Bowel Disease
 Cirrhosis
 Diverticulitis
 GI bleed

Renal

Urolithiasis
 Acute and Chronic Renal Failure
 Pyelonephritis

GU

Urinary Tract Infections
 Incontinence
 BPH
 Erectile Dysfunction
 Urethritis

Reproductive

Endometriosis
 Dysmenorrhea

Musculoskeletal

Carpal Tunnel
 Osteoarthritis
 Osteoporosis
 Sciatica
 DeQuervain's tenosynovitis
 Herniated/ruptured intravertebral disc
 Spondylosis
 Tendonitis
 Bursitis
 Sprains
 Strains
 Fractures
 Dislocations

Rheumatology

Rheumatoid Arthritis
 Lupus
 Fibromyalgia

Neurologic

CVA, TIA
 Seizure disorders
 Bell's Palsy
 Parkinson's Disease
 Alzheimer's Disease
 Dementia
 Cranial/Peripheral nerves

Psychiatric Disorders

Substance abuse/ETHO and Narcotic Withdrawal
 Personality Disorders
 Anxiety Disorders
 Mood Disorders
 Eating disorders
 Bereavement

Health Screening/Maintenance of Asymptomatic Adults

PAP smear
 Fecal occult blood
 Flexible sigmoidoscopy/colonoscopy
 Mammogram
 Adult Immunizations
 Basic EKG Interpretation
 Abnormal Urinalysis

Internal Medicine Clinical Performance Objectives

Upon completion of the **Internal Medicine Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Utilizing all available information sources (patient, family, community, old records) student will elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- C. Perform and document a complete and focused physical examination, appropriate for the patient's age, to include the following:
 1. an organized head-to-toe approach
 2. proper technique
 3. selection of the sections of the physical exam pertinent to the patient's complaint
 4. interpretation of normal and abnormal findings in the context of the patient's history
- D. Read and interpret patients' medical records, as to past medical problems, clinical presentation, laboratory and diagnostic data, therapeutic interventions and socioeconomic information pertinent to factors that affect medical care.
- E. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
 1. the most likely diagnoses, based on history and physical exam data
 2. the most common entities
 3. the most severe and/or life-threatening entities
- F. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent

Internal Medicine Clinical Performance Objectives (continued)

- G. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
1. rationale for utilizing each drug, including mechanism of action
 2. indications, contraindications and adverse reactions
 3. delivery method
 4. potential drug-drug interactions
 5. cost-effectiveness
 6. documented patient education regarding side effects and adherence issues
 7. drugs to avoid in the elderly population
- H. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
1. behavioral and psychosocial interventions
 2. referrals to other health care providers
 3. referrals to community resources
 4. utilization of family resources
 5. plans for follow-up care
- I. Provide and record pertinent patient education regarding disease prevention and health maintenance, which is clearly explained to the patient and checked for understanding, to include:
1. Nutrition
 2. accident and violence prevention (e.g. seat belts, helmets, screening for domestic violence)
 3. physical activity/exercise
 4. pertinent risk factors, including occupation, environment, tobacco, alcohol, other drugs and genetic factors
 5. warning signs/symptoms of diseases
 6. plan for age appropriate screening and periodic health assessment
 7. plans for follow-up
- J. Provide patient counseling to include:
1. adjustment to states of health and disease as related to activities of daily living (ADLs), sexuality, relationships, death and dying
 2. consideration of patient's health beliefs and practices, religious/spiritual beliefs, and lifestyle choices
 3. consideration of socioeconomic, racial, and ethnic factors
 4. family issues
 5. occupational and leisure issues
 6. anticipatory guidance appropriate to patient's age
- K. Monitor patients' progress over time, to include:
1. reassessment of subjective and objective data
 2. reconsideration of differential diagnosis, as needed
 3. modification of management plan, based on patient's health status and adherence issues

Internal Medicine Clinical Performance Objectives (continued)

- L. Chart progress notes following the SOAP format to include:
1. subjective data
 2. objective data
 3. assessment
 4. plan
- M. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- N. Focus on the below items as they relate to the geriatric population:
1. Identify the risk factors and causes of gait disturbances, falls and immobility issues in geriatric patients and discuss management, home safety and preventative strategies for each
 2. Identify barriers to maintaining function and the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
 3. Discuss 3 examples each of ADLs and IADLs
 4. Discuss conditions requiring bed rest; describe the consequences of bed rest and describe prevention methods for pressure ulcers, iatrogenic infections, etc.
 5. Describe the risk factors and consequences of loss of independence
 6. Identify risks for malnutrition and dehydration in the geriatric patient
 7. Differentiate among the etiologies of weight loss and weight gain in the geriatric patient
 8. Develop primary and secondary prevention strategies for disease in geriatric patients, including exercise, nutrition, oral health, immunizations, and screening for diseases
 9. Discuss the health conditions in which a geriatric patient is vulnerable with untreated hearing and/or vision impairment
 10. Describe the causes of visual impairment in the geriatric population
 11. Compare and contrast the causes of hearing loss in the geriatric population
 12. Select evaluation methods for visual and hearing impairment
 13. Outline management plans for geriatric patients with visual and hearing impairments
 14. Identify and appropriately report elder abuse and neglect
 15. Compare and contrast the benefits and consequences of a change from independent living to an assisted living or nursing facility
 16. Discuss ways in which the geriatric patient can effectively manage economic changes, including finances, insurance issues, estate issues, etc.
 17. Discuss the risk factors for social withdrawal in a geriatric patient and identify resources for social support

Internal Medicine Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following symptoms and diagnoses:

PROBLEM LIST

SYMPTOMS

Fatigue and Weakness
 Fever
 Weight loss
 Syncope
 Headache
 Vertigo/dizziness
 Angina
 Chest Pain
 Obesity
 Constipation
 Diarrhea
 Dyspepsia
 Low back pain
 Shoulder, neck, arm pain
 Joint pain/arthritis
 Abdominal pain
 Amenorrhea
 Cough
 Ear Pain
 Nasal congestion/rhinorrhea
 Sore throat
 Vision changes
 Rash
 Pruritus

DIAGNOSES

Cardiovascular

Hypertension
 Congestive Heart Failure
 Valvular Heart Disease
 Coronary artery disease
 Myocardial infarction
 Pericardial disease
 Peripheral vascular diseases
 Thromboembolism
 Arrhythmias
 Cardiomyopathies
 Congenital Heart Defects
 Dyslipidemias
 Edema

DIAGNOSES (cont.)

Respiratory

Asthma
 COPD (emphysema, chronic bronchitis)
 Upper Respiratory Infections
 Influenza
 Pneumonia
 Tuberculosis
 Acute Bronchitis
 Obstructive Sleep Apnea
 Acute Respiratory Distress (Identification)

Ear /Nose/Throat

Sinusitis
 Otitis externa/media
 Epistaxis
 Cerumen Impaction

Endocrine

Goiter
 Hypo/Hyperthyroidism

Hematology/Oncology

Anemia
 Lung Cancer
 Colon Cancer
 Breast Cancer
 Bleeding disorders
 Platelet Disorders
 Hypercoagulable states

Infectious Disease

Sexually transmitted diseases
 HIV infection
 Vaginitis & Cervicitis

Gastroenterology

Pancreatitis
 Hepatitis
 GERD/PUD
 Irritable Bowel Syndrome
 Inflammatory Bowel Disease
 Cirrhosis
 Diverticulitis
 GI bleed

Internal Medicine Clinical Performance Objectives (continued)**PROBLEM LIST
DIAGNOSES (cont.)****Renal**

Urolithiasis
Acute and Chronic Renal Failure
Pyelonephritis

GU

Urinary Tract Infections
Incontinence
BPH
Erectile Dysfunction
Urethritis

Reproductive

Endometriosis
Dysmenorrhea

Musculoskeletal

Carpal Tunnel
Osteoarthritis
Osteoporosis
Sciatica
DeQuervain's tenosynovitis
Herniated/ruptured intravertebral disc
Spondylosis
Tendonitis
Bursitis
Sprains
Strains
Fractures
Dislocations

Rheumatology

Rheumatoid Arthritis
Lupus
Fibromyalgia

Neurologic

CVA, TIA
Seizure disorders
Bell's Palsy
Parkinson's Disease
Alzheimer's Disease
Dementia
Cranial/Peripheral nerves

Psychiatric Disorders

Substance abuse/ETOH and Narcotic Withdrawal
Personality Disorders
Anxiety Disorders
Mood Disorders
Depression
Eating disorders
Bereavement

Geriatric

Heart failure
Arrhythmias
Hypertension and hypotension
Temporal arteritis
Pneumonia
COPD
Constipation and diarrhea
UTI
Incontinence
Benign prostatic hypertrophy
Rheumatoid arthritis
Osteoarthritis
Osteoporosis
Fibromyalgia/Chronic pain
Parkinson's disease
Dizziness/syncope
CVA/TIA
Diabetes mellitus
Hyper/hypocalcemia
Dehydration
Edema
Cancer - solid tumors, leukemias, lymphomas, myeloma
Sexual dysfunction

Health Screening/Maintenance of Asymptomatic Adults

PAP smear
Fecal occult blood
Flexible sigmoidoscopy/colonoscopy
Mammogram
Adult Immunizations
Basic EKG Interpretation
Abnormal Urinalysis

Emergency Medicine Clinical Performance Objectives

Upon completion of the **Emergency Medicine Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Rapidly assess whether the patient's chief complaint and/or physical status indicate a possible life-threatening emergency, and act with appropriate intervention.
- C. Elicit and record, a focused history based on the patient's chief complaint and appropriate for the patient's age and mental status, including HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- D. Perform and record a focused physical examination, appropriate for the patient's age, to include the following:
 1. using an efficient approach
 2. using proper technique, including modifications of technique appropriate for the patient's mobility and mental status
 3. selecting the sections of the physical exam pertinent to the patient's chief complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
- E. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
 1. the most likely diagnoses, based on history and physical exam data
 2. the most common diagnoses
 3. the most severe and/or life-threatening diagnoses
- F. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
 5. time needed to obtain results
- G. Consult providers beyond the emergency department regarding treatment of acute medical/surgical and/or psychiatric conditions.
- H. Identify indications for hospital admission when assessing emergency medical/surgical problems.

Emergency Medicine Clinical Performance Objectives (continued)

- I. Develop, record and implement, as pertinent, a pharmacologic management plan, including fluid replacement and blood products, in the emergency department to include:
 - 1. rationale for utilizing each drug, including mechanism of action
 - 2. indications, contraindications and adverse reactions
 - 3. potential drug-drug interactions
 - 4. cost-effectiveness
 - 5. documented patient education regarding side effects and adherence issues
- J. Provide and record a discharge plan, which is clearly explained to the patient and checked for understanding, to include:
 - 1. nutrition and dietary restrictions
 - 2. physical activity/exercise/work/school
 - 3. warning signs/symptoms of complications
 - 4. discharge treatment plan – pharmacologic and non-pharmacologic
 - 5. plan for outpatient follow-up care, to include primary health care providers, family and community resources
- K. Provide patient and family counseling to include:
 - 1. communication with empathy and compassion
 - 2. establishing a supportive environment for patients and their families to deal with acute emergencies
 - 3. consideration of patients' health beliefs and practices, religious/spiritual beliefs and lifestyle choices
- L. Monitor patients' progress over emergency department admission to include:
 - 1. reassessment of subjective and objective data
 - 2. reconsideration of differential diagnosis, as needed
 - 3. modification of management plan
- M. Chart progress notes in an efficient manner, following the SOAP format to include:
 - 1. subjective data
 - 2. objective data
 - 3. assessment
 - 4. plan
- N. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- O. Demonstrate ability to accurately define patient's overall status (stable, fair, guarded, unstable, critical) according to vital signs and other physical exam findings.
- P. Develop proficiency in evaluating and repairing simple lacerations, including assessing neurovascular status and tissue involvement.
- Q. Demonstrate ability to perform basic ER procedures (if possible), such as I&Ds of abscesses, joint immobilization and relocation.
- R. Develop skills in interpreting normal and commonly encountered abnormal findings on chest and long bone radiographs.
- S. Interpret basic EKGs and identify common abnormal rhythms such as atrial fibrillation, atrial flutter, ventricular tachycardia, torsades de pointes.

Emergency Medicine Clinical Performance Objectives (continued)

- T. Identify and apply components of Glasgow coma scale.
- U. Describe and demonstrate (if possible) proper CPR efforts as a member of emergency department healthcare team.
- V. Discuss appropriate diagnosis and management of various foreign bodies.
- W. Discuss indications for invasive ER procedures, including but not limited to lumbar puncture, chest tube placement, central line placement, and endotracheal intubation; also discuss associated relevant anatomy and potential complications.
- X. Understand indications for oxygen administration and various forms of oxygen delivery such as nasal cannula, full-face mask, and non-rebreather mask.
- Y. Synthesize a management plan for urgent and emergent conditions common to the emergency department setting according to evidence-based standard of care.
- Z. Demonstrate understanding of assessment and management for acute toxicologic ingestion/exposure, including accidental and intentional overdose.

Emergency Medicine Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following symptoms and diagnoses:

PROBLEM LIST

SYMPTOMS

Nausea/vomiting
Diarrhea
SOB
Palpitations
Back Pain
Rash
Toothache
Weakness
Dizziness
Joint Pain
Fever
Abdominal Pain
Dysphagia
Vision Changes
Numbness

DIAGNOSES

Cardiovascular

Chest Pain
Myocardial infarction
Endocarditis
Aortic Stenosis
Mitral Stenosis
Arrhythmias
Hypertensive Emergency

Respiratory

Asthma
Airway Obstruction
COPD
Pneumonia
Pneumothorax
Pulmonary Edema
Pulmonary Embolism
Respiratory Arrest

Infectious Disease

Sepsis
STIs

DIAGNOSES (cont.)

GI

Acute Abdomen
Hepatitis
GI Bleed

GU

Urologic Obstruction/disease

Neurologic

CVA/TIA
Cranial Nerve Damage
Meningitis
Seizures
Headache
Subdural Hematoma
Peripheral Nerve Damage
Concussion

Metabolic

Acid-base disturbance
Diabetic Ketoacidosis
Insulin Shock
Electrolyte Imbalance
Hypercapnia

Trauma

Head injury
Trauma, blunt and sharp
Abuse
Sexual Assault
Burns
Bites: insect and animal (including human)
Lacerations

Emergency Medicine Clinical Performance Objectives (continued)

PROBLEM LIST **DIAGNOSES (cont.)**

Orthopedics

1. Spine Disorders:
 - Jefferson's, odontoid, hangman's, other fracture-dislocations of cervical and thoracolumbar spine, acute hyperextension, herniated discs, stenosis, spondylosis, spondylolisthesis
2. Shoulder Disorders:
 - acromio-clavicular joint injuries, anterior and posterior dislocations, rotator cuff tear, adhesive capsulitis, impingement syndrome, calcific tendinitis
3. Upper Arm and Forearm Disorders:
 - proximal humerus fracture, supercondylar fracture, elbow dislocation, olecranon fracture, proximal radius fracture, Monteggia fracture, greenstick and buckle fractures
4. Hand and Wrist Disorders:
 - Colles', Smith's and Barton's fractures; scaphoid fracture, carpal fractures, lunate dislocation, carpal tunnel syndrome, DeQuervain's tenosynovitis, metacarpal fractures, phalangeal fractures, trigger and mallet deformities, collateral ligament injuries, tendon lacerations, tenosynovitis
5. Pelvis/Acetabulum Fractures
6. Hip/Femur Disorders:
 - femoral neck fracture, intertrochanteric fracture, subtrochanteric fracture, avascular necrosis, slipped capital femoral epiphysis, Legg-Calves-Perthes disease, femoral shaft fracture, distal femur fracture
7. Knee Disorders:
 - patellar fracture, tibial plateau fracture, Baker's cyst, meniscal tears, ligamentous injuries, bursitis, Osgood-Schlatter disease, chondromalacia
8. Fibula Fractures
9. Ankle Disorders:
 - distal fibula fractures, malleolar fractures, sprains, Achilles tendon rupture
10. Foot Disorders:
 - metacarpal fractures, subtalar fracture, calcaneal fracture, plantar fasciitis, Morton's neuroma, bunions, hammertoe and clawfoot deformities
11. Charcot Joint
12. Arthritis
13. Reflex Sympathetic Dystrophy
14. Compartment Syndrome
15. Neoplastic Processes

Pediatrics Clinical Performance Objectives

Upon completion of the **Pediatrics Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.

B. Elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, and Family History, and

Past Medical History to include:

1. prenatal and perinatal history
2. feeding history
3. growth and developmental milestones
4. previous serious illness
5. routine childhood illness
6. hospitalization and surgery
7. injuries
8. immunization status
9. allergies
10. medications and vitamins

Social History to include: (depending on age of child)

1. socioeconomic status
2. day care
3. hobbies, extracurricular activities
4. sleeping habits
5. diet
6. safety issues
7. pets
8. drug, alcohol and tobacco use
9. sexual history

The student will gather historical information including:

1. appropriate use of questions
2. listening to the parent/caretaker and patient
3. an organized approach to eliciting the patient's history
4. interpreting normal and abnormal historical data

Pediatrics Clinical Performance Objectives (continued)

- C. Perform and record a complete and focused physical examination, appropriate for the patient's age, to include the following:
1. Vital signs, skin, HEENT, neck, breasts, chest/lungs, cardiovascular system, abdomen, genitourinary system, musculoskeletal system, rectal, neurological system, general mental status
- The physical exam will include:
1. an organized head-to-toe approach
 2. using proper technique
 3. selecting the sections of the physical exam pertinent to the patient's age and complaint
 4. interpreting normal and abnormal findings in the context of the patient's age and history
- D. Recognize normal developmental milestones.
- E. Understand the Apgar assessment in the neonatal period at 1 minute and 5 minutes. Describe the Apgar score prognostic value for an infant's overall status.
- F. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
1. the most likely diagnoses, based on age, history and physical exam data
 2. the most common entities
 3. the most severe and/or life-threatening entities
- G. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- H. Recognize the indications for tympanometry and audiometry evaluation of hearing and how to interpret result.
- I. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
1. rationale for utilizing each drug, including mechanism of action
 2. indications, contraindications and adverse reactions
 3. potential drug-drug interactions
 4. cost-effectiveness
 5. documented patient education regarding side effects and adherence issues
- J. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
1. behavioral and psychosocial interventions
 2. referrals to other health care providers
 3. referrals to community resources
 4. utilization of family resources
 5. plans for follow-up care
- K. Discuss with parent/guardian the advantages and disadvantages of breast and bottle-feeding, and the optimal schedule for each method.
- L. Assess the child's immunization status and provide guidance for the benefits and possible adverse reactions associated with immunizations.

Pediatrics Clinical Performance Objectives (continued)

- M. List the signs of child abuse and the procedure for reporting incidents to the state's Child Abuse Authorities.
- N. Initiate contact with the poison control center in the event of ingestion or contact exposure and describe how to execute the treatment plan as directed.
- O. Evaluate the presences of foreign bodies in the stomach, intestines and airway.
- P. Provide and record pertinent anticipatory guidance regarding disease prevention and health maintenance, which is clearly explained to the parent/guardian and patient (as appropriate to the patient's age) and checked for understanding, to include:
 - 1. nutrition
 - 2. accident and violence prevention (e.g. seat belts, helmets, screening for domestic violence)
 - 3. plan for age appropriate screening and periodic health assessment
- Q. Provide patient counseling to include:
 - 1. impact of family dynamics on the patient's health
 - 2. consideration of patient and family's health beliefs and practices, religious/spiritual beliefs and lifestyle choices
- R. Monitor patients' progress over time, to include:
 - 1. reassessment of subjective and objective data
 - 2. reconsideration of differential diagnosis, as needed
 - 3. modification of management plan, based on patient's health status and adherence issues
- S. Chart progress notes following the SOAP format to include:
 - 1. subjective data
 - 2. objective data
 - 3. assessment
 - 4. plan
- T. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- U. Accurately measure, record, and interpret height, weight, head circumference, and BMI utilizing CDC standard growth charts.
- V. Demonstrate ability to deliver age-appropriate patient and family education regarding nutrition, behavior, development, sexuality, and substance abuse.
- W. Demonstrate ability to calculate correct drug dosing for both tablets and suspensions for a pediatric patient based on current weight.
- X. Demonstrate understanding and performance of appropriate physical exam on infants, children, and adolescents.
- Y. Identify normal ranges for vital signs for the neonate, child, and adolescent.
- Z. Accurately evaluate APGAR scoring and perform, if possible.
- AA. Utilize current CDC immunization schedules and guidelines to appropriately educate patients and/or caregivers on recommended vaccinations based on the patient's history, including for cases of previously missed/delayed vaccination.
- BB. Discuss contraindications to recommended vaccinations and alternative formulations, if available.

Pediatrics Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following diagnoses:

PROBLEM LIST

DIAGNOSES

Dermatology

Acne
Impetigo
Lice
Pinworms
Scabies
Childhood Exanthems

Infectious Diseases

Cat scratch fever
Chicken Pox
Infectious Mononucleosis
Measles (Rubeola)
Meningitis
Mumps
Rubella
Scarlatina
Thrush

Psychiatry/Mental Health

ADHD
Anorexia – eating disorders
Autism
Downs Syndrome

Neonatal Problems

Fetal Alcohol Syndrome
Jaundice
Patent Ductus Arteriosus
Phenylketonuria
Prematurity
Meconium Aspiration

ENT

Allergies
Epiglottitis
Otitis Externa and Media
Pharyngitis
Sinusitis
Strep Throat

Miscellaneous

Contraception for Adolescents
Failure To Thrive
Febrile Seizure
Fifth Disease

Respiratory

Asthma
Bronchiolitis
Croup
Pneumonia
RSV
Cystic Fibrosis

Cardiovascular

Cardiac Murmurs
Rheumatic Fever
Tetralogy of Fallot

GI

Colic
Constipation
Diarrhea
Intussusception
Pyloric Stenosis
Volvulus

GU

Enuresis
Urinary Tract Infection

Musculoskeletal

Congenital Defects (clubfoot cleft palate)
Orthopedic Conditions (common)
Juvenile Arthritis

Emergent Problems

Drowning
ER Visits
Sudden Infant Death (SIDS)
Poisoning
Seizures
Hirschsprung's Disease
Immunizations
Juvenile Diabetes
Lead Poisoning
Reye's Syndrome
Anemia
Allergies

Psychiatry/Behavioral Medicine Clinical Performance Objectives

Upon completion of the **Psychiatry/Behavioral Medicine Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, prognosis and complications pertinent to each diagnosis.
- B. Elicit and record a complete and focused history using all available resources to include chief complaint, HPI, past medical history, family history and social history, with particular focus on:
 1. psychosocial history
 2. substance use/abuse history
 3. assessment of suicide/homicide risk
 4. history of violence and abuse
 5. prior psychiatric history and treatment
 6. appropriate use of questions
 7. listening to the patient
 8. demonstrating a non-judgmental attitude to the patient
 9. an organized approach to eliciting the patient's history
 10. interpreting normal and abnormal historical data
- C. Perform and record a complete and focused physical examination, appropriate for the patient's age, to include the following:
 1. complete mental status exam
 2. using proper technique, including modifications of technique appropriate for the patient's mobility and mental status
 3. selecting the sections of the physical exam pertinent to the patient's chief complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
- D. Develop and record a diagnosis, based on DSM-IV-TR and DSM-V criteria and format.
- E. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- F. Utilize standardized instruments, as indicated, such as Beck Depression Inventory.
- G. Assess a patient's suicide potential, identify appropriate intervention and demonstrate knowledge of the involuntary commitment process.
- H. Identify symptoms and signs of child abuse, elder abuse and sexual abuse.

Psychiatry/Behavioral Medicine Clinical Performance Objectives (continued)

- I. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
 - 1. rationale for utilizing each drug, including mechanism of action, indications, contraindications and adverse reactions
 - 2. potential drug-drug interactions
 - 3. cost-effectiveness
 - 4. documented patient education regarding side effects and adherence issues
- J. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
 - 1. behavioral, psychosocial interventions, including individual and group therapy
 - 2. referrals to other health care providers
 - 3. referrals to community resources
 - 4. utilization of family resources
 - 5. plans for follow-up care
- K. Monitor patients' progress over time, to include:
 - 1. reassessment of subjective and objective data
 - 2. reconsideration of differential diagnosis, as needed
 - 3. modification of management plan, based on patient's health status and adherence issues
- L. Chart progress notes following the SOAP format to include:
 - 1. subjective data
 - 2. objective data
 - 3. assessment
 - 4. plan
- M. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- N. Discuss psychiatric conditions according to both DSM-IV-TR and DSM-V criteria.
- O. Identify the possible complications of common psychotropic medications and any monitoring related to their use.
- P. Discuss the roles of other healthcare professionals in the psychiatric setting: Social workers, psychologists, licensed counselors.
- Q. Describe indications for ECT as well as the risks and benefits of its use; accurately discuss the process involved in the procedure.
- R. Discuss various forms of psychiatric admission and differentiate those that are voluntary v. involuntary.
- S. Discuss the concept and practical application of "Duty to Warn".
- T. Perform and document an appropriate Mental Status Exam (MSE).
- U. Differentiate substance use, abuse, and dependence.

Psychiatry/Behavioral Medicine Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following diagnoses:

PROBLEM LIST

DIAGNOSES

Addictive behaviors
Mood disorders
Anxiety disorders
Eating disorders
Mental retardation
Personality disorders
Schizophrenic disorders
Somatoform disorders
Organic mental disorders

Women's Health Clinical Performance Objectives

Upon completion of the **Women's Health Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Elicit and record a complete and focused history, using all available resources, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
 5. emphasis on the menstrual cycle, sexual history, gynecologic history, and contraceptive history
- C. Perform and record a complete and focused physical examination, appropriate for the patient's age, to include the following:
 1. an organized head-to-toe approach
 2. using proper technique
 3. selecting the sections of the physical exam pertinent to the patient's complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
 5. emphasis on speculum examination, bimanual examination, breast exam and abdominal exam
- D. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
 1. the most likely diagnoses, based on history and physical exam data
 2. the most common entities
 3. the most severe and/or life-threatening entities
- E. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- F. Collect adequate cervico-vaginal cytologic specimens for PAP smears and microscopic inspections.
- G. Identify the recommended guidelines for frequency of PAP smears and mammograms.
- H. Describe the indications for colposcopic cervical examination following an abnormal PAP smear.

Women's Health Clinical Performance Objectives (continued)

- I. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
 1. rationale for utilizing each drug, including mechanism of action
 2. indications, contraindications and adverse reactions
 3. potential drug-drug interactions
 4. cost-effectiveness
 5. documented patient education regarding side effects and adherence issues
- J. Discuss the methods of contraception and family planning, including their relative advantages, disadvantages, effectiveness (differentiating perfect and typical use), and adverse effects.
- K. List the physiologic changes and signs of pregnancy
- L. Describe the criteria and resources available for termination of pregnancy
- M. Discuss and provide patient education regarding normal fertility.
- N. Demonstrate ability to provide preconception counselling
- O. Implement current ACOG guidelines regarding recommended obstetric labs/screening and follow-up.
- P. Describe routine prenatal care, including the role of electronic fetal monitoring, ultrasound and the biophysical profile to determine fetal well-being. Identify the indications for non-stress and oxytocin challenge testing.
- Q. Identify medical problems that may result in complications during pregnancy, including diabetes, hypertension, anemia, thyroid disorders, cardiovascular problems and vaginal bleeding
- R. List the three stages of labor. Identify the reasons for delivery once the amniotic sac has ruptured. Describe use of the fern test to determine the presence of amniotic fluid
- S. Demonstrate understanding and management of obstetric complications and emergencies, including but not limited to placenta previa, placenta abruption, retained placental material, and postpartum hemorrhage
- T. Assist the obstetrician, as directed, during cesarean sections and vaginal deliveries. Identify techniques for clearance of the infant's airway and respiratory stimulation at the time of delivery
- U. Identify female causative factors of and diagnostic testing for infertility including structural and endocrine pathology
- V. Identify indications for various invasive gynecological procedures, such as LEEP, colposcopy, cone biopsy, hysterosalpingography, and pelvic ultrasound
- W. Recognize the occurrence of common breast masses and identify the appropriate work-up and treatment
- X. Identify the role of genetic testing in regard to breast and gynecologic cancer risk, detection/screening, and management
- Y. Discuss the physiologic changes during perimenopause and menopause and identify the indications and contraindications for hormone replacement therapy
- Z. Educate regarding recommended gynecological screenings according to applicable American Cancer Society (ACS), United States Preventative Task Force (USPTF), and American College of Obstetrics and Gynecology (ACOG) guidelines

Women's Health Clinical Performance Objectives (continued)

- AA. Assist the gynecologist, as directed, during surgical procedures
- BB. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
 - 1. behavioral and psychosocial interventions
 - 2. referrals to other health care providers
 - 3. referrals to community resources
 - 4. utilization of family resources
 - 5. plans for follow-up care
- CC. Provide and record pertinent patient education regarding disease prevention and health maintenance, which is clearly explained to the patient and checked for understanding, to include:
 - 1. nutrition
 - 2. accident and violence prevention (e.g. seat belts, helmets, screening for domestic violence)
 - 3. physical activity/exercise
 - 4. pertinent risk factors, including occupation, environment, tobacco, alcohol, other drugs and genetic factors
 - 1. warning signs/symptoms of diseases
 - 2. plan for age appropriate screening and periodic health assessment
- DD. Provide patient counseling to include:
 - 1. adjustment to states of health and disease as related to ADLs, sexuality, relationships, death and dying
 - 2. consideration of patient's health beliefs and practices, religious/spiritual beliefs and lifestyle choices
 - 3. family issue
 - 4. occupational and leisure issues
 - 5. anticipatory guidance appropriate to patient's age
- EE. Monitor patients' progress over time, to include:
 - 1. reassessment of subjective and objective data
 - 2. reconsideration of differential diagnosis, as needed
 - 3. modification of management plan, based on patient's health status and adherence issues
- FF. Chart progress notes following the SOAP format to include:
 - 1. subjective data
 - 2. objective data
 - 3. assessment
 - 4. plan
- GG. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.

Women's Health Clinical Performance Objectives (continued)

The student will demonstrate the knowledge and skills described above pertaining to the following diagnoses:

PROBLEM LIST DIAGNOSES

Gynecology

Amenorrhea
Atrophic vaginitis
Condyloma acuminata
Dysmenorrhea
Dysmenorrhagia
Dysfunctional uterine bleeding (DUB)
Dyspareunia
Endometriosis
Fibroid tumors
Fibrocystic breast disease
Galactorrhea
Hemophilus vaginalis (Gardnerella)
Infertility
Pediculosis
Pelvic inflammatory disease
Scabies
Incontinence
Urinary tract infection
Vaginal candida

Obstetrics

Abortion
Abruptio placenta
Anemia
Ectopic pregnancy
Endometriosis
Gestational diabetes mellitus
Hyperemesis gravidarum
Lactation
Mastitis
Placenta previa
Post-partum care
Pre-eclampsia, eclampsia
Prenatal care/labs
Pre-term labor
TORCH infections

Sexually transmitted diseases

chlamydia
gonorrhea
herpes simplex
HIV
syphilis
trichomoniasis

Cancer

breast
cervical
endometrial
fallopian tube
ovarian
uterine
vaginal
vulvar

Surgery Clinical Performance Objectives

Upon completion of the **Surgery Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Utilizing all available information sources (patient, family, community, old records) student will elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- C. Perform and record a complete surgical admission, pre-operative and post-operative focused physical examination, appropriate for the patient's age, to include the following:
 1. using an efficient approach
 2. using proper technique, including modifications of technique appropriate for the patient's mobility and mental status
 3. selecting the sections of the physical exam pertinent to the patient's chief complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
- D. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- E. Consult providers beyond the surgical department regarding treatment of patients' medical and/or psychiatric problems.
- F. Develop and record a surgical diagnosis and plan, based on the patient's complaint, to include a consideration of:
 1. the risks and benefits of surgery for the patient's condition
 2. medical conditions that impact on the patient's surgical risk
- G. Demonstrate knowledge of the informed consent process.
- H. Scrub and gown in surgical attire following guidelines for maintaining a sterile field.
- I. Identify commonly used surgical instruments and suture materials and describe their use.
- J. Recognize the responsibilities of each member of the surgical team.
- K. Assist in surgical procedures as directed by the surgical preceptor.

Surgery Clinical Performance Objectives (continued)

- L. Assess and monitor patients' status post-operatively in the recovery room.
- M. Provide patient and family counseling to include:
 - 1. communication with empathy and compassion
 - 2. establishing a supportive environment for patients and their families to deal with acute emergencies
 - 3. consideration of patients' health beliefs and practices, religious/spiritual beliefs and lifestyle choices
- N. Develop, record and implement a pre-op and post-op pharmacologic management plan, including fluid replacement, blood products and pain management to include:
 - 1. Rationale for utilizing each drug, including mechanism of action
 - 2. Indications, contraindications and adverse reactions
 - 3. potential drug-drug interactions
 - 4. cost-effectiveness
 - 5. documented patient education regarding side effects and adherence issues
- O. Care for post-surgical patients, including wound care and recognition of infection.
- P. Provide and record a discharge plan, which is clearly explained to the patient and checked for understanding, to include:
 - 1. wound care and expected stages of healing
 - 2. pain management
 - 3. nutrition and dietary restrictions
 - 4. physical activity/exercise/work/school
 - 5. warning signs/symptoms of complications
 - 6. discharge treatment plan – pharmacologic and non-pharmacologic
 - 7. plan for outpatient follow-up care, to include primary health care providers, surgical follow-up, family and community resources
- Q. Chart progress notes in an efficient manner, following the SOAP format to include:
 - 1. subjective data
 - 2. objective data
 - 3. assessment
 - 4. plan
- R. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- S. Compare and contrast various types of suture material and indications for their use.
- T. Perform suturing and stapling of surgical incisions as well as two-handed and instrument assisted ties of suture material. Perform removal of sutures and staples, if possible.
- U. Demonstrate understanding of wound care principles.
- V. Identify and assess common surgical complications including but not limited to atelectasis, ileus, wound infection, dehiscence, bleeding, and sepsis.
- W. Identify pathogens responsible for common surgical infections, including MRSA.

General Surgery Clinical Performance Objectives (continued)

X. Perform the following procedures under direct supervision:

1. local anesthetic block
2. digital block
3. repair simple superficial and complex lacerations or incisions
4. incision and drainage of abscess
5. excision of small skin growths, such as moles and cysts
6. debridement of necrotic tissues
7. change sterile dressings

The student will demonstrate the knowledge and skills described above pertaining to the following symptoms and diagnoses:

PROBLEM LIST

SYMPTOMS

Symptoms, Syndromes, Miscellaneous

Acute Abdomen
GI bleeding
Gynecomastia
Mediastinal diseases
Shock
MRSA
Gangrene

DIAGNOSES

Cardiovascular

Peripheral vascular diseases
Varicose veins
Carotid Stenosis

Cancers

Breast
Colon
Gastric
Lung
Pancreatic
Prostate
Testicular
Lymphoma

DIAGNOSES (cont.)

GI

Appendicitis
Cholelithiasis
Cholecystitis
Crohn's disease, Ulcerative Colitis
Hemorrhoids
Intestinal Obstruction
Hepatic and biliary tract diseases
Morbid Obesity

GU

Hernias: abdominal, femoral, inguinal
Hydrocele
Kidney stones
Testicular torsion
Varicocele

Post-operative complications

Dehiscence
Embolism
Fever
Hematoma
Ileus
Infection
Phlebitis
Pneumonia
Urinary tract infection
Biopsy and aspiration of breast masses
Fluid and electrolyte management
Trauma, blunt and sharp
Wound care
Wound healing

Elective – Medical Subspecialty Clinical Performance Objectives

Upon completion of the **Elective – Medical Subspecialty Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Utilizing all available information sources (patient, family, community, old records) student will elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- C. Perform and document a complete and focused physical examination, appropriate for the patient's age, to include the following:
 1. an organized head-to-toe approach
 2. proper technique
 3. selection of the sections of the physical exam pertinent to the patient's complaint
 4. interpretation of normal and abnormal findings in the context of the patient's history
- D. Read and interpret patients' medical records, as to past medical problems, clinical presentation, laboratory and diagnostic data, therapeutic interventions and socioeconomic information pertinent to factors that affect medical care.
- E. Develop and record a differential diagnosis, based on the patient's complaint, to include a consideration of:
 1. the most likely diagnoses, based on history and physical exam data
 2. the most common entities
 3. the most severe and/or life-threatening entities
- F. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent

Elective – Medical Subspecialty Clinical Performance Objectives (continued)

- G. Develop, record and implement, as pertinent, a pharmacologic management plan to include:
1. rationale for utilizing each drug, including mechanism of action
 2. indications, contraindications and adverse reactions
 3. delivery method
 4. potential drug-drug interactions
 5. cost-effectiveness
 6. documented patient education regarding side effects and adherence issues
 7. drugs to avoid in the elderly population
- H. Develop, record and implement, as pertinent, a non-pharmacologic management plan to include as appropriate:
1. behavioral and psychosocial interventions
 2. referrals to other health care providers
 3. referrals to community resources
 4. utilization of family resources
 5. plans for follow-up care
- I. Provide and record pertinent patient education regarding disease prevention and health maintenance, which is clearly explained to the patient and checked for understanding, to include:
1. nutrition
 2. accident and violence prevention (e.g. seat belts, helmets, screening for domestic violence)
 3. physical activity/exercise
 4. pertinent risk factors, including occupation, environment, tobacco, alcohol, other drugs and genetic factors
 5. warning signs/symptoms of diseases
 6. plan for age appropriate screening and periodic health assessment
 7. plans for follow-up
- J. Provide patient counseling to include:
1. adjustment to states of health and disease as related to activities of daily living (ADLs), sexuality, relationships, death and dying
 2. consideration of patient's health beliefs and practices, religious/spiritual beliefs, and lifestyle choices
 3. consideration of socioeconomic, racial, and ethnic factors
 4. family issues
 5. occupational and leisure issues
 6. anticipatory guidance appropriate to patient's age
- K. Monitor patients' progress over time, to include:
1. reassessment of subjective and objective data
 2. reconsideration of differential diagnosis, as needed
 3. modification of management plan, based on patient's health status and adherence issues

Elective – Medical Subspecialty Clinical Performance Objectives (continued)

- L. Chart progress notes following the SOAP format to include:
1. subjective data
 2. objective data
 3. assessment
 4. plan
- M. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner.
- N. Focus on the below items as they relate to the geriatric population:
1. Identify the risk factors and causes of gait disturbances, falls and immobility issues in geriatric patients and discuss management, home safety and preventative strategies for each
 2. Identify barriers to maintaining function and the ability to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs)
 3. Discuss 3 examples each of ADLs and IADLs
 4. Discuss conditions requiring bed rest; describe the consequences of bed rest and describe prevention methods for pressure ulcers, iatrogenic infections, etc.
 5. Describe the risk factors and consequences of loss of independence
 6. Identify risks for malnutrition and dehydration in the geriatric patient
 7. Differentiate among the etiologies of weight loss and weight gain in the geriatric patient
 8. Develop primary and secondary prevention strategies for disease in geriatric patients, including exercise, nutrition, oral health, immunizations, and screening for diseases
 9. Discuss the health conditions in which a geriatric patient is vulnerable with untreated hearing and/or vision impairment
 10. Describe the causes of visual impairment in the geriatric population
 11. Compare and contrast the causes of hearing loss in the geriatric population
 12. Select evaluation methods for visual and hearing impairment
 13. Outline management plans for geriatric patients with visual and hearing impairments
 14. Identify and appropriately report elder abuse and neglect
 15. Compare and contrast the benefits and consequences of a change from independent living to an assisted living or nursing facility
 16. Discuss ways in which the geriatric patient can effectively manage economic changes, including finances, insurance issues, estate issues, etc.
 17. Discuss the risk factors for social withdrawal in a geriatric patient and identify resources for social support

Elective – Medical Subspecialty Clinical Performance Objectives (continued)

The below problem list is a general guide. Actual objectives will vary by specialty. Students should discuss and define at minimum 5 site-specific objectives with their preceptor.

PROBLEM LIST**SYMPTOMS**

Fatigue and Weakness
 Fever
 Weight loss
 Syncope
 Headache
 Vertigo/dizziness
 Angina
 Chest Pain
 Obesity
 Constipation
 Diarrhea
 Dyspepsia
 Low back pain
 Shoulder, neck, arm pain
 Joint pain/arthritis
 Abdominal pain
 Amenorrhea
 Cough
 Ear Pain
 Nasal congestion/rhinorrhea
 Sore throat
 Vision changes
 Rash
 Pruritus

DIAGNOSES**Cardiovascular**

Hypertension
 Congestive Heart Failure
 Valvular Heart Disease
 Coronary artery disease
 Myocardial infarction
 Pericardial disease
 Peripheral vascular diseases
 Thromboembolism
 Arrhythmias
 Cardiomyopathies
 Congenital Heart Defects
 Dyslipidemias
 Edema

DIAGNOSES (cont.)**Respiratory**

Asthma
 COPD (emphysema, chronic bronchitis)
 Upper Respiratory Infections
 Influenza
 Pneumonia
 Tuberculosis
 Acute Bronchitis
 Obstructive Sleep Apnea
 Acute Respiratory Distress (Identification)

Ear /Nose/Throat

Sinusitis
 Otitis Externa/Media
 Epistaxis
 Cerumen Impaction

Endocrine

Goiter
 Hypo/Hyperthyroidism

Hematology/Oncology

Anemia
 Lung Cancer
 Colon Cancer
 Breast Cancer
 Bleeding disorders
 Platelet Disorders
 Hypercoagulable states

Infectious Disease

Sexually transmitted diseases
 HIV infection
 Vaginitis & Cervicitis

Gastroenterology

Pancreatitis
 Hepatitis
 GERD/PUD
 Irritable Bowel Syndrome
 Inflammatory Bowel Disease
 Cirrhosis
 Diverticulitis
 GI bleed

Elective – Medical Subspecialty Clinical Performance Objectives (continued)**PROBLEM LIST
DIAGNOSES (cont.)****Renal**

Urolithiasis
Acute and Chronic Renal Failure
Pyelonephritis

GU

Urinary Tract Infections
Incontinence
BPH
Erectile Dysfunction
Urethritis

Reproductive

Endometriosis
Dysmenorrhea

Musculoskeletal

Carpal Tunnel
Osteoarthritis
Osteoporosis
Sciatica
DeQuervain's tenosynovitis
Herniated/ruptured intravertebral disc
Spondylosis
Tendonitis
Bursitis
Sprains
Strains
Fractures
Dislocations

Rheumatology

Rheumatoid Arthritis
Lupus
Fibromyalgia

Neurologic

CVA, TIA
Seizure disorders
Bell's Palsy
Parkinson's Disease
Alzheimer's Disease
Dementia
Cranial/Peripheral nerves

Psychiatric Disorders

Substance abuse/ETOH and Narcotic Withdrawal
Personality Disorders
Anxiety Disorders
Mood Disorders
Depression
Eating disorders
Bereavement

Geriatric

Heart failure
Arrhythmias
Hypertension and hypotension
Temporal arteritis
Pneumonia
COPD
Constipation and diarrhea
UTI
Incontinence
Benign prostatic hypertrophy
Rheumatoid arthritis
Osteoarthritis
Osteoporosis
Fibromyalgia/Chronic pain
Parkinson's disease
Dizziness/syncope
CVA/TIA
Diabetes mellitus
Hyper/hypocalcemia
Dehydration
Edema
Cancer - solid tumors, leukemias, lymphomas, myeloma
Sexual dysfunction

Health Screening/Maintenance of Asymptomatic Adults

PAP smear
Fecal occult blood
Flexible sigmoidoscopy/colonoscopy
Mammogram
Adult Immunizations
Basic EKG Interpretation
Abnormal Urinalysis

Elective – Surgical Subspecialty Clinical Performance Objectives

Upon completion of the **Elective - Surgical Subspecialty Clinical Experience**, based on reading and supervised clinical practice, the student will demonstrate knowledge and competence pertaining to each of the Instructional Objectives below, as they relate to the symptoms and diagnoses in the Problem List. Student will demonstrate attainment of a strong knowledge base, clinical skills, self-directed learning, self-assessment, clinical reasoning, professional behavior and team skills.

Pertaining to the problem list below, the student will:

- A. Demonstrate knowledge of the etiology, epidemiology, pathophysiology, anatomy, prognosis and complications pertinent to each diagnosis.
- B. Utilizing all available information sources (patient, family, community, old records) student will elicit and record a complete and focused history, appropriate for the patient's age, including Chief Complaint and HPI with pertinent Review of Systems, Past Medical History, Family History and Social History to include:
 1. appropriate use of questions
 2. listening to the patient
 3. an organized approach to eliciting the patient's history
 4. interpreting normal and abnormal historical data
- C. Perform and record a complete surgical admission, pre-operative and post-operative focused physical examination, appropriate for the patient's age, to include the following:
 1. using an efficient approach
 2. using proper technique, including modifications of technique appropriate for the patient's mobility and mental status
 3. selecting the sections of the physical exam pertinent to the patient's chief complaint
 4. interpreting normal and abnormal findings in the context of the patient's history
- D. Select and interpret diagnostic studies to evaluate the differential diagnosis, including the following for each study:
 1. risks and benefits
 2. sensitivity and specificity
 3. cost effectiveness
 4. obtaining informed consent
- E. Consult providers beyond the surgical department regarding treatment of patients' medical and/or psychiatric problems.
- F. Develop and record a surgical diagnosis and plan, based on the patient's complaint, to include a consideration of:
 1. the risks and benefits of surgery for the patient's condition
 2. medical conditions that impact on the patient's surgical risk
- G. Demonstrate knowledge of the informed consent process
- H. Scrub and gown in surgical attire following guidelines for maintaining a sterile field
- I. Identify commonly used surgical instruments and suture materials and describe their use
- J. Recognize the responsibilities of each member of the surgical team
- K. Assist in surgical procedures as directed by the surgical preceptor
- L. Assess and monitor patients' status post-operatively in the recovery room

Elective – Surgical Subspecialty Clinical Performance Objectives (cont.)

- M. Provide patient and family counseling to include:
1. communication with empathy and compassion
 2. establishing a supportive environment for patients and their families to deal with acute emergencies
 3. consideration of patients' health beliefs and practices, religious/spiritual beliefs and lifestyle choices
- N. Develop, record and implement a pre-op and post-op pharmacologic management plan, including fluid replacement, blood products and pain management to include:
1. Rationale for utilizing each drug, including mechanism of action
 2. Indications, contraindications and adverse reactions
 3. potential drug-drug interactions
 4. cost-effectiveness
 5. documented patient education regarding side effects and adherence issues
- O. Care for post-surgical patients, including wound care and recognition of infection.
- P. Provide and record a discharge plan, which is clearly explained to the patient and checked for understanding, to include:
1. wound care and expected stages of healing
 2. pain management
 3. nutrition and dietary restrictions
 4. physical activity/exercise/work/school
 5. warning signs/symptoms of complications
 6. discharge treatment plan – pharmacologic and non-pharmacologic
 7. plan for outpatient follow-up care, to include primary health care providers, surgical follow-up, family and community resources
- Q. Chart progress notes in an efficient manner, following the SOAP format to include:
1. subjective data
 2. objective data
 3. assessment
 4. plan
- R. Make verbal case presentations to the clinical preceptor to include pertinent elements listed above, in an organized and time-efficient manner
- S. Complete pre-operative assessments.
- T. Compare and contrast various types of suture material and indications for their use.
- U. Perform suturing and stapling of surgical incisions as well as two-handed and instrument assisted ties of suture material. Perform removal of sutures and staples, if possible.
- V. Demonstrate understanding of wound care principles.
- W. Identify and assess common surgical complications including but not limited to atelectasis, ileus, wound infection, dehiscence, bleeding, and sepsis.
- X. Identify pathogens responsible for common surgical infections, including MRSA.

Elective – Surgical Subspecialty Clinical Performance Objectives (cont.)

The below problem list is a general guide. Actual objectives will vary by specialty. Students should discuss and define at minimum 5 site specific objectives with their preceptor.

PROBLEM LIST

SYMPTOMS

Symptoms, Syndromes, Miscellaneous

Acute Abdomen
GI bleeding
Gynecomastia
Mediastinal diseases
Shock
MRSA
Gangrene

DIAGNOSES

Cardiovascular

Peripheral vascular diseases
Varicose veins
Carotid Stenosis

Cancers

Breast
Colon
Gastric
Lung
Pancreatic
Prostate
Testicular
Lymphoma

GI

Appendicitis
Cholelithiasis
Cholecystitis
Crohn's disease, Ulcerative Colitis
Hemorrhoids
Intestinal Obstruction
Hepatic and biliary tract diseases
Morbid Obesity

DIAGNOSES (cont.)

GU

Hernias: abdominal, femoral, inguinal
Hydrocele
Kidney stones
Testicular torsion
Varicocele

Post-operative complications

Dehiscence
Embolism
Fever
Hematoma
Ileus
Infection
Phlebitis
Pneumonia
Urinary tract infection
Biopsy and aspiration of breast masses
Fluid and electrolyte management
Trauma, blunt and sharp
Wound care/healing

Elective – Surgical Subspecialty Clinical Performance Objectives (cont.)

PROBLEM LIST DIAGNOSES (cont.)

Orthopedics

1. Spine Disorders:
 - Jefferson's, odontoid, hangman's, other fracture-dislocations of cervical and thoracolumbar spine, acute hyperextension, herniated discs, stenosis, spondylosis, spondylolisthesis
2. Shoulder Disorders:
 - acromio-clavicular joint injuries, anterior and posterior dislocations, rotator cuff tear, adhesive capsulitis, impingement syndrome, calcific tendinitis
3. Upper Arm and Forearm Disorders:
 - proximal humerus fracture, supercondylar fracture, elbow dislocation, olecranon fracture, proximal radius fracture, Monteggia fracture, greenstick and buckle fractures
4. Hand and Wrist Disorders:
 - Colles', Smith's and Barton's fractures; scaphoid fracture, carpal fractures, lunate dislocation, carpal tunnel syndrome, DeQuervain's tenosynovitis, metacarpal fractures, phalangeal fractures, trigger and mallet deformities, collateral ligament injuries, tendon lacerations, tenosynovitis
5. Pelvis/Acetabulum Fractures
6. Hip/Femur Disorders:
 - femoral neck fracture, intertrochanteric fracture, subtrochanteric fracture, avascular necrosis, slipped capital femoral epiphysis, Legg-Calves-Perthes disease, femoral shaft fracture, distal femur fracture
7. Knee Disorders:
 - patellar fracture, tibial plateau fracture, Baker's cyst, meniscal tears, ligamentous injuries, bursitis, Osgood-Schlatter disease, chondromalacia
8. Fibula Fractures
9. Ankle Disorders:
 - distal fibula fractures, malleolar fractures, sprains, Achilles tendon rupture
10. Foot Disorders:
 - metacarpal fractures, subtalar fracture, calcaneal fracture, planta fasciitis, Morton's neuroma, bunions, hammertoe and clawfoot deformities
11. Charcot Joint
12. Arthritides
13. Reflex Sympathetic Dystrophy
14. Compartment Syndrome
15. Neoplastic Processes

PROFESSIONAL GROWTH OBJECTIVES

The student's attitudes and behavior that contribute to Professional Growth will be monitored by core PA faculty and clinical preceptors throughout the clinical experience. The student will demonstrate Professional Growth by:

- A. Developing and maintaining good interpersonal relationships with patients as demonstrated by:
 - 1. encouraging discussion of problems and/or questions
 - 2. recognizing verbal and non-verbal clues
 - 3. offering support and reassurance
 - 4. listening attentively
 - 5. draping appropriately, offering explanations and displaying a professional demeanor during examinations and procedures
- B. Seeking and maintaining competence by:
 - 1. demonstrating evidence of self-directed learning (reading, research, utilizing principles of evidence-based medicine)
 - 2. completing clinical experience in accordance with assigned schedule, with punctuality
 - 3. adhering to the clinical experience objectives as set forth
- C. Demonstrating professionalism by:
 - 1. recognizing one's limitations and informing preceptors when assigned task are not appropriate to current knowledge and/or skills
 - 2. performing all clinical activities with the awareness of and under the supervision of the site preceptor or his/her designee
 - 3. eliciting and demonstrating receptivity to constructive feedback
 - 4. forming and maintaining positive relationships with patients, peers, staff and supervisors
 - 5. maintaining a calm and reasoned manner in stressful and/or emergency situations
 - 6. showing respect for patients and maintaining appropriate confidentiality of the patient's record
 - 7. demonstrating awareness and sensitivity to patients' cultural beliefs and behaviors
 - 8. displaying a high level of motivation and interest
 - 9. dressing and grooming appropriately
 - 10. adhering to the AAPA Code of Ethics and HIPAA

EVALUATION PROCESS AND DOCUMENTS

Clinical Performance Evaluation (CE 1-9)

- Mid-Rotation Evaluation of PA Student's Clinical Performance
- End-Rotation Evaluation of PA Student's Clinical Performance
- End of Rotation Evaluation of Preceptor

Evaluation Process

Preceptors are required to provide formal, written feedback regarding the student's performance at the end of each Clinical Experience. The student is responsible for presenting the evaluation form to the preceptor at the appropriate time. Following completion of the evaluation form, the preceptor may return the form to the student, return the form via fax to **(412) 365-2952** or mail the form to:

**Attention: Clinical Coordinator
Chatham University
Physician Assistant Studies Program
Woodland Road
Pittsburgh, PA 15232**

The form must be completed by the assigned preceptor and/or other clinician at the assigned clinical site who can best evaluate the student's performance. We ask that the preceptor keep a copy of the final evaluation for at least 5 weeks after the student leaves the site. The student is also encouraged to seek feedback from others whom he/she has worked with at the site. The evaluations are used by the Clinical Coordinators (in conjunction with a variety of other parameters as outlined in the course syllabi) to assign the final grade for the clinical experience. Preceptors are encouraged to give an honest appraisal of the student's performance, identifying areas of strength and weakness. Written comments are especially helpful in evaluating the student's progress and identifying areas for further study.

Should an issue arise warranting the attention of the Clinical Coordinators, preceptors are encouraged to call the Clinical Coordinators immediately at (412) 365-1170 or (412) 365-2765.

Upon request, we will provide preceptors with a compilation of the students' written comments about the experience with the preceptor and the clinical site.

At the conclusion of each CE assignment, we ask each student and each preceptor to complete evaluation forms based on different criteria relating to their experience. Our students electronically submit their evaluations while the preceptors can manually complete their evaluations. In this handbook are examples of evaluations that the student and the preceptor will be asked to complete. We greatly appreciate any and all feedback we receive from you.

Clinical Year Passport (see Appendix A)

During clinical year, Chatham PA students are provided a Clinical Passport. This is a small booklet including worksheets of documentation types and procedures that the student is expected to encounter during their clinical year. Item listed for each type of medical documentation and clinical procedure are to be initialed and dated by a preceptor when they are completed by the student with proficiency. The student is to have his/her clinical passport with them at all times during rotations.



CHATHAM UNIVERSITY PHYSICIAN ASSISTANT STUDIES

Woodland Road • Pittsburgh, PA 15232

412-365-1829 • fax: 412-365-2952

Mid-Rotation Evaluation of PA Student's Clinical Performance

Student Name: _____

CE #: _____

Preceptor Name: _____ Specialty: _____

Site Name: _____

Please check the appropriate box based on your mid-rotation evaluation of the student.

	Borderline or Does Not Meet Expectation	Meets	Exceeds	Comment/Individual Learning Plans
<u>Professionalism</u> professional demeanor, recognition of personal limitations, respect for patients, honesty and ethics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Attitude</u> initiative, teachability, dependability, team member function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Applied Knowledge</u> general medical knowledge, test selection and interpretation, patient education/health promotion, integration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<u>Skill</u> interviewing, therapeutic relationships, physical exam, written communication, oral communication, management plans.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Strengths:

Areas for Improvement:

Has the student ever been late or absent? Yes No If yes, how many times? _____

Preceptor's Signature: _____ Date: _____

PA Student Signature: _____ Date: _____

(student signature required)



CHATHAM UNIVERSITY PHYSICIAN ASSISTANT STUDIES

Woodland Road • Pittsburgh, PA 15232

412-365-1829 • fax: 412-365-2952

End-Rotation Evaluation of PA Student's Clinical Performance

Student Name: _____

CE #: _____

Preceptor Name: _____

Specialty: _____

Site Name: _____

Please circle the appropriate number based on your final evaluation of the student.	5=Exceptional, 4=Above Average, 3=Average, 2=Below Average, 1=Poor					
1. The student obtains and documents an appropriate problem-focused history utilizing all available information sources, (such as patient, family and community members).	5	4	3	2	1	N/A
2. Student demonstrates clear and precise oral presentation skills.	5	4	3	2	1	N/A
3. The student performs and documents an appropriate physical examination .	5	4	3	2	1	N/A
4. The student is able to discuss common problems in this specialty including pathophysiology, diagnosis, treatment and follow-up.	5	4	3	2	1	N/A
5. The student appropriately interprets diagnostic tests including laboratory results and imaging studies.	5	4	3	2	1	N/A
6. The student generates and implements an appropriate management plan including treatment, follow-up plans and patient education/counseling.	5	4	3	2	1	N/A
7. The student is able to discuss the appropriate use of medications related to such issues as dosage, indications, contraindications, interactions, complications, metabolism, excretion and mutagenicity.	5	4	3	2	1	N/A
8. The student properly performs and documents procedures under the supervision of the preceptor.	5	4	3	2	1	N/A
9. The student demonstrates proper sterile technique, proper identification of surgical instruments and proper suture and knot-tying techniques . (if applicable)	5	4	3	2	1	N/A
10. The student is able to describe and discuss routine health maintenance .	5	4	3	2	1	N/A
11. The student is able to describe and discuss public health issues related to this specialty.	5	4	3	2	1	N/A

End-Rotation Evaluation of PA Student's Clinical Performance (continued)

PA Student Name: _____

CE #: _____

Please circle the appropriate number based on your final evaluation of the student.	5=Exceptional, 4=Above Average, 3=Average, 2=Below Average, 1=Poor					
12. Student Behaviors:						
a. The student demonstrates professional attitude as evidenced by appropriate dress and grooming.	5	4	3	2	1	N/A
b. The student demonstrates professional attitude as evidenced by punctuality and timeliness.	5	4	3	2	1	N/A
c. The student demonstrates self-directed learning by identifying and resolving learning issues (i.e. problem solving, critical thinking skills).	5	4	3	2	1	N/A
d. The student is considerate and is willing to help others on the team.	5	4	3	2	1	N/A
e. The student demonstrates initiative and willingness to work.	5	4	3	2	1	N/A
f. The student recognizes limitations of own knowledge and asks for help as appropriate.	5	4	3	2	1	N/A
g. The student demonstrates compassionate bedside manner.	5	4	3	2	1	N/A
h. The student demonstrates clear understanding of the role of a Physician Assistant.	5	4	3	2	1	N/A

Overall Performance	Exceptional	Above Average	Average	Below Average	Poor
13. Rate the student's overall performance.	<input type="checkbox"/>				

14. Has the student **called off from or been late** to assigned clinical days? Yes No
 If yes, the student has called off from or been late to assigned clinical days, **how often?** Times late: _____
 Times absent: _____

15. Additional Comments:

Preceptor's Signature: _____

Date: _____

PA Student Signature: _____

Date: _____

(Student signature required only if evaluation is less than average)



CHATHAM UNIVERSITY PHYSICIAN ASSISTANT STUDIES

Woodland Road • Pittsburgh, PA 15232

412-365-1829 • fax: 412-365-2952

End-Rotation Evaluation of Preceptor

Student Name: _____

CE #: _____

Preceptor Name: _____

Specialty: _____

Site Name: _____

Date: _____

Place an "X" in the appropriate column.	Exceptionally (5)	Above Average (4)	Average (3)	Below Average (2)	Poorly (1)	N/A
The preceptor facilitated my learning experience by listening to patient presentations, questioning me about my learning issues and providing appropriate feedback.	<input type="checkbox"/>					
The preceptor provided opportunity for additional work in areas of self-identified needs.	<input type="checkbox"/>					
The preceptor provided resources to facilitate the research of learning issues.	<input type="checkbox"/>					
The preceptor provided opportunities to mature as a clinician by incremental increases in direct patient care, enabling the development of "autonomy" within the confines of the setting and the PA role.	<input type="checkbox"/>					
The preceptor provided opportunities to enhance professional development (e.g. grand rounds, team/staff/committee meetings).	<input type="checkbox"/>					
	Exceptional (5)	Above Average (4)	Average (3)	Below Average (2)	Poor (1)	N/A
Based on the above, rate the preceptor and site overall	<input type="checkbox"/>					

Instructions: Written comments are mandatory.

List rotation strengths.	
List rotation weaknesses.	
Comment on Preceptor's teaching style.	
Provide any useful information regarding the following:	
Housing	
Meals	
Parking	
Any additional comments you have:	

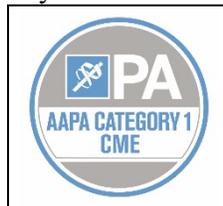
BENEFITS OFFERED BY CHATHAM UNIVERSITY FOR PRECEPTING

Listed below are the Chatham University benefits are you entitled to for precepting.

Please note that before you can receive a Chatham University Identification Card, or Chatham E-mail Account, you must first contact Bette Weger, the Clinical Coordinator Program Assistant at B.Weger@Chatham.edu to have a personal Chatham ID Number created, which will then allow you to request a Chatham ID Card or Chatham E-mail Account.

1. Continuing Medical Education Credits

Physicians receive Category II CME Credits toward the AMA Physician's Recognition Award (PRA).
Physician Assistants receive Category I or II CME Credits.



Chatham University PA Program is approved by the American Academy of Physician Assistants to award AAPA Category 1 CME credit to eligible physician assistant preceptors. This approval is valid for one clinical year beginning June 7, 2021. This program was planned in accordance with AAPA's CME Standards. Physician assistants may earn a maximum of 20 hours of AAPA Category 1 CME credit for clinical precepting during any single calendar year.

Our program will provide you with your total precepting hours each summer at the completion of the rotational year. You are responsible for submitting your credits to the appropriate agencies.

2. Clinical Assistant Professor Appointment for the Chatham University Physician Assistant Studies Program.

3. Chatham University E-mail Account

You are entitled to a complimentary Chatham University E-mail Account, which can be utilized on or off campus. You can also use your e-mail account login to access the Jennie King Mellon Library resources and databases through the myChatham web page at <http://my.chatham.edu>. Chatham University email is the preferred account to use for all communication with students and University members.

4. Chatham University Identification Card

You may use your Chatham University ID Card for the following:

Jennie King Mellon Library

All library patrons must present a valid Chatham University ID Card in order to borrow library material. Please call for library hours at (412) 365-1670.

University Events:

You may attend concerts, lectures and sports events held on campus at faculty rates.

Athletic and Fitness Center

All AFC patrons must present a valid Chatham University ID Card in order to utilize the facilities. Please check the website or call the AFC (412-365-1625) for hours of operation.

5. Chatham University Tuition Waiver

The Tuition Waiver is good for three credits of Chatham coursework for the preceptor. At your request, you will be provided with a non-transferable voucher that expires within one year of the date issued. Credits can be used for undergraduate, graduate and on-line courses (excluding Physician Assistant, Physical Therapy and Occupational Therapy). The tuition waiver can be granted annually. The voucher can only be used toward coursework credits leading to a Chatham degree one time per individual, but may be used for non-degree credits during any year(s) in which you are a Clinical Instructor.

6. Tuition Discount Program

Chatham is extending a tuition discount to all employees of your organization. Through this program, you or any of your employees who are considering completing an undergraduate or graduate degree, can receive **20% off the cost of the tuition** at Chatham. There is a range of programs including fully online RN-BSN, MSN and DNP nursing programs; an online MBA with Healthcare Management concentration; a Master of Accounting; online bachelor completers programs in Business Administration and many more (excludes OT, PT, and PA Programs). To participate in this program, please contact gradadmission@chatham.edu. Our Office of Admissions will be glad to work with you to provide materials and/or visit your location to communicate to your employees about this benefit.

FREQUENTLY ASKED QUESTIONS

1. Can my colleagues participate in the training of the student and/or can they cover for me in my absence?

Yes, as long as the PA, MD, DO, or NP is a part of your practice or specialty group.

2. Can the student work on weekends and/or be on-call?

Yes. The student's hours are determined at your discretion.

3. Can the student accompany me on patient rounds at different facilities?

Yes, as long as Chatham University has an affiliation agreement with the facility/facilities. If you have questions about what hospitals, long-term care facilities and nursing homes with which we have affiliation agreements, please contact the clinical coordinators.

4. Can the student document in the patient charts?

The preceptor ultimately decides if a student should document in the charts. If the preceptor permits it, all documentation should be reviewed and signed by the preceptor. Hospitals may have their own guidelines/bylaws. It is the responsibility of the preceptor to know these guidelines and to follow the appropriate procedures, instructing the student accordingly. Currently, there are no provisions for PA students to bill for services under Medicare or any other insurance carrier.

5. What do you want the student to get out of this rotation? Are there any defined Learning Issues?

“Clinical Performance Objectives” (found in this handbook) can be used as a guide for clinical experiences. The student should also identify his or her own specific learning objectives for the rotation.

6. Can I provide the student with reading assignments? Do the students have assignments for Chatham?

Yes. We welcome the opportunity for you as the clinical preceptor to assign readings or assignments that you feel are beneficial to the student's experience at your site. We also have various assignments specific to each rotation that student must complete.

7. What is the student capable of and allowed to do in the operating room?

During the first year of our Physician Assistant program, the students are familiarized with aseptic technique, surgical scrubbing, surgical instruments, gowning & gloving, suturing, knot tying, and catheterization.

Students are encouraged to act as 1st and 2nd assistants in surgery in order to gain as much “hands-on” surgical experience as possible.

8. What do I do if the student is not performing to my expectations?

First, please address your concerns directly with the student.

If this approach fails, please contact one of the Chatham PA Program Clinical Coordinators at 412-365-2765 or 412-365-1170

If a student fails a rotation, that student will be placed at a different site to make up the rotation.

9. What if by precepting a PA student, I would like to hire a PA? Where do I go from here?

Please refer to the section in this handbook entitled “Tips on Hiring a Physician Assistant.”

PHYSICIAN ASSISTANT ORGANIZATIONS

American Academy of Physician Assistants (AAPA)

The American Academy of Physician Assistants (AAPA) is the national professional society for Physician Assistants. Founded in 1968, the Academy has chapters in all 50 states, the District of Columbia, and Guam. They also have chapters that represent physician assistants working for the Public Health Service, the Department of Veteran's Affairs, and all branches of the military.

The mission of the AAPA is to "promote quality, cost effective, and accessible health care and to promote the professional and personal development of Physician Assistants". Major activities to accomplish this goal include government relations, public education, research and data collection, and professional development.

Eighty percent of all practicing physician assistants are members of AAPA. Members are graduates of accredited physician assistant programs and/or those who are nationally certified. Students at accredited programs are also eligible for membership.

The AAPA's Physician Assistant Foundation (PAF) provides funds for scholarships and research on the PA profession. The web site for AAPA provides a variety of information on the profession.

For more information, contact:

American Academy of Physician Assistants
950 North Washington Street
Alexandria, VA 22314-1552
Phone: (703) 836-2272
Fax: (703) 684-1924
Web site: www.aapa.org
E-mail: aapa@aapa.org

National Commission on Certification of Physician Assistants (NCCPA)

The National Commission on Certification of Physician Assistants (NCCPA) is an independent organization established to assure the competency of physician assistants. The NCCPA was formed in 1975 by the AAPA and other health professional associations in order to administer a national certifying examination to graduates of accredited PA programs. The initial examination (PANCE) and the re-certification examination (PANRE) are designed to test the medical knowledge and clinical skills of Physician Assistants.

For more information, contact:

NCCPA
12000 Findley Road, Suite 200
Duluth, GA 30097-1409
Phone: (678) 417-8100
Fax: (678) 417-8135
Web site: www.nccpa.net
E-mail: nccpa@nccpa.net

PHYSICIAN ASSISTANT ORGANIZATIONS (continued)

Physician Assistant Education Association (PAEA)

Founded in 1972 to help maintain the high quality of PA education, PAEA's objectives are to encourage communication among the programs and to serve as a national information center on PA education.

PAEA publishes the "National Directory of PA Programs", giving complete information on the names, locations, requirements, tuition, length, and degree(s) awarded for each of the accredited PA programs. The directory is available to the public for a small fee.

For more information, contact:

Physician Assistant Education Association
655 K Street NW Suite 700
Washington, DC 20001
Phone: (703) 548-5538
Fax: (703) 684-1924
Web site: www.paeonline.org

Pennsylvania Society of Physician Assistants (PSPA)

The Pennsylvania Society of Physician Assistants (PSPA) was established in 1976 to act as a representative of all physician assistants within the Commonwealth of Pennsylvania.

For more information, contact:

Pennsylvania Society of Physician Assistants
PO Box 128
Greensburg, PA 15601
Phone: (724) 836-6411
Fax: (724) 836-4449
Web site: www.pspa.net
E-mail: pspa@pspa.net

HIRING A PHYSICIAN ASSISTANT

1. Employer information can be found at the Pennsylvania Society of Physician Assistants (PSPA) web site: <http://pspa.net/employment/employersrecruiters/employer-career-center/>
(For those outside of PA, contact your state's board of medicine for details specific to your state.)
2. Various forms from the State Board of Medicine (such as the Application for Registration as a Supervising Physician of a Physician Assistant) can be found at the Pennsylvania Department of State web site:
<http://www.dos.pa.gov/ProfessionalLicensing/BoardsCommissions/Medicine/Pages/default.aspx#.VRWQUfzF-OU>
3. Physician Assistant information about reimbursement can be found at the web site for the DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services:
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf>

PHYSICIAN ASSISTANT FACTS

1. There are an estimated 139,688 practicing physician assistants, according to the NCCPA 2019 Statistical Profile of Certified Physician Assistants.
2. There are 254 Physician Assistant programs that are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA). ARC-PA is recognized by the Council for Higher Education Accreditation (CHEA).
3. Typical PA programs last for 24-32 months.
4. All 50 states, the District of Columbia and Guam have laws that authorize PA's to prescribe medications.
5. According to the 2019 AAPA Salary Report, the estimated median annual salary for a PA is \$105,000. For the new graduate the average median salary is estimated at \$95,000.
6. Every state along with the District of Columbia, Guam, the Commonwealth of the Northern Mariana Islands, the Virgin Islands and Puerto Rico has its own laws and regulations governing PA practice.
7. Only graduates of an accredited PA school can take the Physician Assistant National Certification Exam (PANCE).
8. A PA must take the Physician Assistant National Recertification Exam every ten years depending on his/her current recertification cycle. Recertification requirements may depend on the state in which they practice.
9. Every two years a PA must obtain 100 hours of continuing medical education to maintain his/her national certification.
10. Certification and licensure requirements may vary by state. Please see <https://www.aapa.org/WorkArea/DownloadAsset.aspx?id=599> or your state's medical board for current requirements. <https://www.aapa.org/threecolumnlanding.aspx?id=347>

APPENDIX A: CLINICAL YEAR PASSPORT

INSTRUCTIONS

Welcome to your clinical year!

This passport will serve as a **GUIDE** to ensure you are exposed to and experienced in aspects of medicine that will prepare you to be a general medicine physician assistant.

This book should remain with you at **ALL** times. When you complete a listed requirement with proficiency and to your preceptor's satisfaction, have your preceptor initial and date each item. Keep in mind that once you complete the listed requirements, you should **CONTINUE** to log additional items in E*Value.

It is highly recommended that you make copies of your passport as items are completed in case your passport is lost or misplaced.

The items listed are not all-inclusive. You should continue to seek knowledge and experience from all aspects of medicine and from every preceptor you meet.

There are note pages at the end of this book. We recommend that you use these pages to list reminders of common things you will need to know (i.e. normal lab values or differential diagnoses for common complaints).

As always, contact your clinical advisor at any time with questions or concerns. Good luck, have fun, and learn **A LOT!**

APPENDIX A: CLINICAL YEAR PASSPORT (continued)

PATIENT ENCOUNTERS

Listed below are common symptoms that you will see during your clinical year.
This list is for YOUR reference to aid your self-directed learning.

SYMPTOMS

Abdominal Pain

Allergic Reaction

Altered Mental Status

Amenorrhea

Anorexia

Anxiety

Attention Problems

Bleeding

Burns

Constipation

Cough

Chest Pain

Depression

Developmental Delays

Diarrhea

Ear Pain

Edema

Fatigue

Fever

Flank Pain

Headache

Heartburn

Heart Palpitations

Hematochezia

Infertility

Injury

Insomnia

Joint Pain

Low Back Pain

Menstrual Irregularities

Nausea/Vomiting

Paresthesias

Pelvic Pain

Rash

Respiratory Distress

Seizures

Shortness of Breath

Sore Throat

Syncope

Upper Respiratory Symptoms

Urinary Problems

Vaginal Discharge

Visual Disturbance

Weakness

Weight Gain/Loss

APPENDIX A: CLINICAL YEAR PASSPORT (continued)

DOCUMENTATION		
Note	Initials	Date
Admit Orders		
Discharge Summary		
History and Physical - Adult		
History and Physical - Child		
History and Physical - Geriatric		
Procedure Note		
SOAP Note - Adult		
SOAP Note - Child		
SOAP Note – Geriatric		
SOAP Note – OB/GYN		
SOAP Note – Psychiatric		
Infant Visit		
Child Visit		
Adolescent Visit		

APPENDIX A: CLINICAL YEAR PASSPORT (continued)

PROCEDURES		
Procedure	Initials	Date
Aseptic technique before surgery <ul style="list-style-type: none"> Surgical scrubbing is thorough and for required time; done without rings or jewelry Proper gowning and gloving 		
Assist in Surgery (1st Assist if possible) <ul style="list-style-type: none"> Maintenance of sterile field and technique Prompt and appropriate response to directives 		
Suturing <ul style="list-style-type: none"> Preparation and maintenance of sterile field Placement of sutures to cause proper alignment of wound/incision and closure of tissue borders Appropriate tension of placed sutures Proper knot tying technique 		
Suture/Staple Removal <ul style="list-style-type: none"> Removes all sutures/staples in entirety without disruption of wound healing 		
Foley Catheter Insertion/Removal <ul style="list-style-type: none"> Proper preparation of patient and equipment (sterile if insertion; aseptic if removal) Pre-test integrity of Foley balloon with air or sterile solution (for insertion only) Accurate insertion into urethra and inflation of balloon for insertion OR deflation of balloon prior to removal 		
Local Anesthesia <ul style="list-style-type: none"> Proper aseptic technique Appropriate handling and disposal of sharps 		
Incision and Drainage <ul style="list-style-type: none"> Proper aseptic technique Appropriate instrument use to identify and disrupt loculations Adequate removal of purulent material Appropriate amount of sterile packing placed without contamination or loss of packing edge 		
Wound cleansing and dressing <ul style="list-style-type: none"> Proper materials use and technique without unnecessary contamination Appropriate choice and application of dressing 		
Joint/limb immobilization <ul style="list-style-type: none"> Appropriate joint positioning for type of splint or cast Adequate amount of splinting or casting material used without unnecessary waste 		
Clinical Breast Exam <ul style="list-style-type: none"> Inspects thoroughly in sitting and supine positioning Palpation done while supine with arm positioned overhead Adequate pressure throughout all breast regions, including axillary tail Consistently applies strip or circular method Assesses for nipple discharge 		

APPENDIX A: CLINICAL YEAR PASSPORT (continued)

PROCEDURES (cont.)		
Procedure	Initials	Date
Pelvic Exam <ul style="list-style-type: none"> • Maintains proper positioning and draping of patient • Bimanual exam includes palpation of uterus and adnexal structures • Exam completed with minimal discomfort 		
Pap Smear or Vaginal Probe <ul style="list-style-type: none"> • Properly prepares and inserts speculum • Exam completed with minimal discomfort 		
Rectal Exam <ul style="list-style-type: none"> • Maintains proper positioning and draping of patient • Use of lubricant • Exam completed with minimal discomfort 		
Stool for occult blood <ul style="list-style-type: none"> • Proper technique • Accurate analysis 		
Urinalysis/Dipstick <ul style="list-style-type: none"> • Proper technique • Accurate analysis of each component 		
EKG Interpretation <ul style="list-style-type: none"> • Identification of basic structures (e.g. P-wave, QRS complex, T-wave) • Accurate determination of heart rate • Identification of characteristic pathologic EKGs (e.g. STEMI, A-fib, SVT, PACs, Atrial flutter) 		
Imaging Evaluation (CT or MRI) <ul style="list-style-type: none"> • Identification of basic anatomical structures • Identification of areas of abnormality 		
Imaging Evaluation (X-ray) <ul style="list-style-type: none"> • Identification of basic anatomical structures • Identification of areas of abnormality 		
Laboratory Evaluation - CMP		
Laboratory Evaluation - CBC		
Laboratory Evaluation*		
<i>* Other examples – Troponins, Lipid, PT/INR, TSH. Each laboratory evaluation must be signed off and for a different study.</i>		