MEDEX Northwest

2014 – 2015

Clerkship Preceptor's Manual

University of Washington
School of Medicine
Seattle WA

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CLERKSHIP PRECEPTOR'S MANUAL: 2014–2015

WELCOME TO MEDEX NORTHWEST

Thank you for your involvement with the MEDEX Northwest Physician Assistant Program. For over 40 years, MEDEX has trained a diverse group of individuals for physician assistant practice in the Pacific Northwest. From its beginnings, the MEDEX program has worked collaboratively with physicians, administrators, legislators, other health professionals, community leaders and researchers to respond to the changing health care environment. MEDEX has a strong primary care tradition with special emphasis on training physician assistants to increase access for medically underserved people.

Key to the success of the program is the contributed time and energy of a broad group of preceptors who provide clinical opportunities and instruction to MEDEX students. This manual is intended to provide an overview of the MEDEX program and the PA profession as well as specific guidelines and evaluation tools for the clinical components of the MEDEX program.

In addition to supporting and evaluating its students, the MEDEX faculty and administration regularly provide technical assistance to clinics employing PAs or considering the development of PA jobs. This technical assistance can include the creation of job descriptions, assistance with recruitment and retention, facilitation of contract negotiation and advice on licensure and reimbursement issues. We hope that you will see us as a resource.

Again, thank you for your involvement with the MEDEX program.

Mission Statement

MEDEX Northwest is a regional program that educates physician assistants in a proven tradition of excellence.

MEDEX Northwest, the University of Washington School of Medicine's Physician Assistant program, is committed to educating experienced health personnel from diverse backgrounds to practice medicine with physician supervision. The program provides a broad, competency-based curriculum that focuses on primary care with an emphasis on underserved populations. MEDEX encourages life-long learning to meet ever-changing health care needs. As a pioneer in PA education, MEDEX continues to be innovative in identifying, creating and filling new niches for PAs as a strategy for expanding health care access.

PROGRAM POLICIES AND PROCEDURES FOR THE CLINICAL YEAR

In addition to the policies included in the Student Handbook, the program has the following specific policies for the clinical year.

Grading for each quarter of the clinical year will be credit/no credit. In order to receive a 'credit' grade, students must have demonstrated passing performance on written assignments, examinations, clinical write-ups, preceptor evaluations, site visit assessments and other assignments.

All assignments must be submitted according to the timeline provided. Late assignments may result in an 'Incomplete' grade for that quarter.

The program has strict deadlines for the completion of assignments. These include the completion of rotation assignments, site and preceptor evaluations, patient logs, research papers, written assignments, online exams, board review questions, case presentations, projects and other course assignments. Failure to submit these materials by the designated deadlines can result in the withdrawal or removal of students from clinical training sites and ultimately the placement of the student on academic warning or probation, and may also delay program completion.

Students who receive a failing evaluation at a site visit will be placed on academic warning, or probation, and may be removed from the clinical site. Typical concerns include the following:

a. failure to complete and submit written assignments or charting by scheduled deadlines,
b. unsatisfactory progress in professional development, attitudes and professional conduct,
c. unexcused or unexplained absence (including tardiness or early departure) from a clinical site during a scheduled rotation,
d. failure of a site visit,
e. failure to receive a passing 'quarterly evaluation' or 'final evaluation' on a clinical rotation or preceptorship,
f. unprofessional interactions and/or inappropriate behavior at a clinical site,
g. misrepresentation of the student role,
h. practicing with inappropriate or absent supervision,
i. failure to obtain co-signature on patient records.

Students will be placed on academic warning or probation if they receive a failing or borderline evaluation from a clinical rotation or a preceptorship quarter.

In order to facilitate role transition, students are strongly discouraged from working during the clinical year. Students may be placed on academic warning, or probation or extended in the program if clinic time or academic performance is adversely impacted by outside work.

MEDEX meets with students to plan the clinical year. However, the program has the final determination of where each student is placed for clinical experiences.

Students may participate in only those clinical experiences to which they are formally assigned. Because the program has specific agreements with clinical sites, it is inappropriate and illegal for a student to present him- or herself (wearing a PA student name tag) as a PA student outside of

clinical assignments arranged by the program. Please contact the clinical education office with any questions.

There will be no discrimination against any program participant or applicant because of race, color, religion, national origin, age, disability, status as a Vietnam era or disabled veteran, sex or sexual orientation, nor will the university or the training site engage in such discrimination in their employment or personnel policies.

The University of Washington will obtain verification of its students' current immunizations and maintain records at the Hall Health Center, as is the policy for all University of Washington health science students. Hall Health informs MEDEX whether its students are in compliance with immunization requirements.

The University of Washington cannot require its students to purchase health or disability insurance, but strongly encourages each student to do so. It is our recommendation that students participating in the program acquire comprehensive health and accident insurance that will provide continuous coverage during participation in the program. MEDEX informs its students that they are responsible for their own health care costs, health insurance coverage, and their own health needs.

Students will have the status of learners and should not replace training site personnel. Any service rendered by students is incidental to the educational purpose of the clinical education program.

In the event that a student sustains a needle-stick injury or other substantial exposure to bodily fluids of another person or other potentially infectious material while on rotation at the training site—or is involved in or present during any incident related to professional liability, claims or other risk management issues—he or she should consult the incident protocol card and the risk management card, both provided by the program. The source patient's HBV, HCV and HIV status will be determined by the training site in the usual manner to the extent possible. The training site does not accept liability for any illness or injury subsequent to such accidental exposure.

Contacts Following Exposure to Blood or Bodily Fluids

MEDCON	(if not in Seattle ask to be connected to numbers below)	(206) 543-5560
UWMC Campus Health	(7:30 am – 4:30 pm M-F)	(206) 598-4848
UWMC Emergency Department	(24 hours)	(206) 598-4000
Dr. Doug Paauw (pager)		(206) 598-6190

PHYSICIAN ASSISTANT STUDENTS AND MEDICARE COMPLIANCE

Physician Assistant (PA) students—as well as medical students and other health professions students—seek to participate fully during clinical rotations, including hands-on participation in patient care. It is essential that such clinical opportunities exist to maximize the student's learning experience and to prepare students to deliver appropriate healthcare services to patients upon graduation. However, clinical training sites may be unsure how student participation in patient care may impact billing.

It is important to note that students (medical, PA, PT, nursing, etc.) are not licensed to provide healthcare services. Since they are not licensed providers, their services cannot be billed, except in the circumstances described below. The following definitions and discussion apply specifically to the Medicare program, and may or may not be applicable to other third-party payers.

Centers for Medicare and Medicaid Services

The guidelines published by CMS address primarily the instruction of residents and interns. The discussion related to students is limited to the following paragraph.

> Any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements (other than the review of systems [ROS] and/or past, family, and/or social history [PFSH], which are taken as part of an evaluation and management [EM] service and are not separately billable). Students may document services in the medical record; however, the teaching physician may only refer to the student's documentation of an EM service that is related to the ROS and/or PFSH. The teaching physician may not refer to a student's documentation of physical examination findings or medical decision making in his or her personal note. If the student documents EM services, the teaching physician must verify and redocument the history of present illness and perform and redocument the physical examination and medical decision making activities of the service. [Excerpted from *Guidelines for Teaching Physicians, Interns and Residents*.]

Discussion

Medicare billing is based on the documentation entered by the preceptor (with the possible exception of ancillary services such as ROS and PFSH as listed above), meaning that preceptor-entered documentation must contain sufficient detail to support the claim being submitted. Diagnostic examination and writing chart notes (whether in the record or as shadow notes) are integral to student learning, and preceptors are encouraged to support student participation to the full extent that their demonstrated skills indicate. Regarding evaluation and management services, the Medicare program has indicated that the services provided by a medical student are billable under the preceptor if personal supervision (in the same room) is provided when the

student performs the service (section 15016 of Part 3). If the preceptor was not in the same room, he or she must redocument the findings. The American Academy of Physician Assistants believes that this same principle should apply to PA students.

- The authorized Medicare practitioner/clinical preceptor is ultimately responsible for assuring the highest quality patient care;
- The authorized Medicare practitioner/clinical preceptor is the only individual who has the ability to submit a claim for care delivered to Medicare beneficiaries;
- The clinical preceptor's responsibility is to insure that the appropriate standard of care is received by the patient;
- On each visit where evaluation and management services are provided, or medical/surgical procedures are performed, the patient should always be personally seen and treated by the clinical preceptor;
- The clinical preceptor must supervise the activities of the student;
- PA students are not covered under the teaching physician/resident billing rules. The Medicare authorized practitioner/clinical preceptor must always supervise and/or provide the necessary components of a given service provided to the Medicare beneficiary.

Definitions

Student (applies to medical student, PA student or other health professions student): An individual who participates in an accredited educational program (e.g., medical or PA school) that is not an approved graduate medical education program. A student is never considered to be an intern or a resident. Medicare does not pay for services provided by students.

Teaching relationship (physician working with medical or PA students): Medical students (or other types of students, such as PA, PT or nursing students, etc.) are not licensed to practice medicine and therefore may not bill for services they provide in whole or in part. The only documentation they may contribute to the support of billable service is documentation such as Review of Systems and Past, Family and Social History. If a medical (or PA) student documents other parts of the encounter, the teaching physician must redocument that information.

Physically Present (or in the same room): The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.

Faculty members on the MEDEX clinical team are available by phone for further discussion of Medicare requirements and approaches to incorporating students into your practice efficiently. MEDEX plans to expand this discussion: please contribute questions and suggestions as desired.

This document is a compilation and adaptation of materials prepared by the AAPA (Michael Powe, Vice President), the UW Office of Risk Management and CMS.

MEDEX NORTHWEST HISTORY

1968 The MEDEX Demonstration Project, jointly sponsored by the University of Washington School of Medicine and the Washington State Medical Association, was funded by the National Center for Health Services Research.

1969 The first MEDEX class of 15 former military medical corpsmen was selected and began training.

1971 An amendment to the Washington State Medical Practice Act was passed, allowing physician assistants to practice medicine under the supervision of a licensed physician.

1972 The Department of Health Services at the University of Washington School of Public Health and Community Medicine provides a long-term home for the MEDEX program.

1974 MEDEX dropped its restriction on admitting only ex-military corpsmen. Nurses and allied health workers were admitted for the first time.

1977 The Washington State Board of Medical Examiners amended its Rules and Regulations to allow prescriptive practice for physician assistants.

1981 Due to cutbacks in federal support, the MEDEX program was given 'self-sustaining' status by the University of Washington, allowing the program to retain tuition and fees.

1983 The curriculum was expanded to 18 months to include an additional third quarter of didactic training and a quarter of clinical clerkships (in addition to the six-month primary care preceptorship) in the senior year. Class size expanded from 21 to 24 students.

1985 MEDEX students are required to complete an 'inpatient' experience as a portion of their clinical rotations.

1986 The university awards the first degree specific to the MEDEX program, the Bachelor's Degree in Clinical Health Services. (Students had previously been eligible for a generic bachelor's degree through the University Extension.)

1987 The Washington State Legislature passes legislation to place a PA on the Board of Medical Examiners.

1988 WAPA sponsors successful legislation to no longer allow foreign-trained doctors to register as PAs.

1990 Part-time slots are added to allow Seattle area health care providers to attend MEDEX while maintaining jobs. Enrollment is now 32 full-time and 6 part-time students entering each year.

- Washington PA status is changed from 'registered' to 'licensed' by legislative action. The PA on the Board of Medical Examiners is given full voting privileges.

1991 A PA is added to the Medical Disciplinary Board by legislative action. Class size is expanded to 36 full-time in addition to 6 part-time students.

1992 Class size expanded to 40 full-time students. Clinical training is expanded by an additional three months, making the clinical phase 10 months in length.

1993 Washington Health Reform Bill includes funding (an initial $150,000, declining annually) for MEDEX. MEDEX begins training in Sitka AK for 12 additional entering students.

1994 The state of Alaska does not fund a second class at the Sitka site; however, the experiences gained in Alaska and the $150,000 from the Washington state legislature allows the program to begin training students in Yakima, WA.

- MEDEX moves back into the School of Medicine as part of the Department of Medical Education (later Medical Education and Biomedical Informatics).

1997 MEDEX begins satellite training in Spokane WA and continues training in Yakima. State Family Medicine funds are provided to the program to support interdisciplinary activities with the UW's Family Medicine Network.

1998 Washington's state legislature provides further support (an initial $150,000, declining annually) for the maintenance of the Spokane site.

1999 MEDEX Northwest celebrates its 30th anniversary year. The first class from Spokane graduates. MEDEX expands the classes in Yakima and Spokane to 18 seats each. The part-time option is suspended.

2001 A basic science summer course is added to the curriculum.

- MEDEX adds a faculty member based at the University of Alaska Anchorage to work with clinical placements and the MEDEX-UAA bachelor's degree link.

2002 A new required clerkship rotation in ambulatory care is added and the preceptorship is extended by one month, lengthening the clinical phase of training.

2004 Anatomy & Physiology becomes a partly on-line course and is required for all entering students. MEDEX is now a 24-month program.

- MEDEX formalizes a link with the UW Extended Master of Public Health to offer a dual degree program to qualifying PA students.

2005 MEDEX begins development of a new midlevel dental health aide therapy program in Alaska, called DENTEX.

2008 MEDEX collaborates with the University of Alaska in Anchorage to develop an additional Anchorage didactic site.

- MEDEX makes the decision to train master's-level students at its Seattle and Spokane sites, and bachelor's- and certificate-level students in Yakima and Anchorage.

2008 The first DENTEX class graduates, and the new dental health aide therapists begin to practice in local communities.

2009 MEDEX Northwest celebrates its 40th anniversary year.

- The first class at the new Anchorage site enrolls on the University of Alaska Anchorage campus. MEDEX now has four classroom sites accepting over 100 students per year.
- MEDEX enrolls the first master's-level classes in Seattle and Spokane.
- MEDEX enrolls the first students in the post-graduate Extended Master of Clinical Health Services degree program for practicing PAs.

2011 MEDEX moves within the School of Medicine from the Department of Medical Education and Biomedical Informatics to the Department of Family Medicine.

THE MEDEX PROGRAM

Program Goals

MEDEX Northwest exists to train physician assistants and to promote their establishment in stable employment settings throughout the Northwest. Our approach is distinctive because we accept into the program only those individuals who have substantive prior experience in healthcare. Our curriculum builds on this prior knowledge and experience in a flexible way, integrating basic sciences with clinical skills so that at the conclusion of the training the graduate should be able to perform with a high level of competence most of the routine tasks required for employment in a family practice setting. These tasks have been defined and continue to be refined by surveys of medical practices and by analyses of the patient populations seen by our students throughout their clinical training.

Although the program has specific training objectives, we recognize that preceptors may wish to add additional training in areas that are of importance in the individual practice situation. We encourage this. Our only request is that core items be dealt with adequately.

Year 1: Didactic Year

The initial four quarters of instruction occur at the University of Washington. The general educational objectives of this year are:

1. to master the basic science underlying medical practice;
2. to become competent in adult and pediatric data collection, data analysis and synthesis;
3. to gain the ability to recognize and treat common and emergent problems as presented in primary care settings;
4. to become proficient in selected technical skills;
5. to increase behavioral medicine skills;
6. to learn to function in an appropriate PA role, with knowledge of limitations and respect for the PA–physician relationship.

We try to individualize instruction based on student needs, projected practice demands, faculty capabilities and supporting resources. Because the trainees enter MEDEX with varied backgrounds and experiences, it is not unusual to find some variation in competency levels and educational needs. Exams are administered at regular intervals. Students are expected to achieve competency before moving on to other areas.

Several instructional methods are utilized including classroom lectures, seminars, workshops, clinical and laboratory experiences, individual and group feedback sessions, clinical simulations, and independent learning experiences. Students are encouraged to use library as well as computer and Internet resources.

OVERVIEW OF MEDEX CURRICULUM

Summer (& preceding spring)

Summer A-Term: MEDEX 451/551 – Anatomy & Physiology (6 credits)

Anatomy & Physiology includes online coursework during the spring quarter prior to arrival at the Seattle campus. Students are taught the anatomy and physiology of the following organ systems: endocrine, immune, respiratory, cardiovascular, gastrointestinal, genitourinary, gynecological, integumentary, musculoskeletal and neurologic, with a focus on clinical examples of anatomic and physiologic principles encountered in primary care practice. Course is delivered partly online, with two weeks of in-class participation and testing.

(Note: This course may not be claimed for financial aid prior to summer quarter since students are not formally registered in courses until June/July.)

Summer B-Term: MEDEX 450/550 – Basic Science in Clinical Medicine for Physician Assistants (6 credits)

This course is an intensive review of, and in some cases introduction to, important basic science topics relevant to clinical medicine at the physician assistant level. The material is necessary to the understanding and integration of information that will be presented throughout the remainder of the MEDEX curriculum. Topics to be covered include cell biology, genetics, immunology and microbiology.

Autumn

MEDEX 452/552 –Pathophysiology for Primary Care (6 credits)

This course covers basic pathological and pathophysiological concepts of diseases commonly encountered in primary care practice. Pathophysiology is studied per organ system.

MEDEX 453/553 – Basic Clinical Skills (5 credits)

In this course, students develop mastery of a screening history and physical examination and thorough data-collection skills. In addition, the students learn branching examinations of the major organ systems, medical recordkeeping and verbal presentation skills.

MEDEX 457/557 – Behavioral Medicine I (2 credits)

Learn process skills and interpersonal skills needed for primary care practice, assessment skills needed for the diagnosis of emotional problems, and management skills used in primary care practice to deal with these problems.

MEDEX 470/570 – Professional Role Development I (1 credit)

PRD is an introduction to the PA role including relationships with other health professions, role transitions and emerging issues in primary care. This course emphasizes learning among classmates about their prior roles in a wide range of urban and rural communities.

MEDEX 473/573 – Technical Skills I (1 credit)

Through hands-on experience, this course introduces clinical skills and procedures common in the primary care setting. Instruction format includes lecture, online lab tutorial, clinical reasoning problems and workshops. The first quarter focuses on clinical lab medicine that includes blood studies, urine studies and microscopy. Workshops include heart sounds, funduscopy, oral health and IV/venipuncture.

Winter

MEDEX 454/554 – Adult Medicine I (7 credits)
Through lecture, small group discussion and problem-based learning formats, this course provides a problem-oriented approach to the diagnosis and management of common primary care conditions. The organ system approach covers HEENT, rheumatology, gynecology (including STDs and HIV), gastroenterology, nephrology, urology and hematology.

MEDEX 456/556 – Maternal & Child Health I (3 credits)
This course is designed to acquaint students with principles of primary care pediatrics. This quarter covers newborn, well child, adolescent and sports exams as well as pediatric health maintenance and an overview of normal pregnancy and delivery in the primary care setting. A systems-oriented approach to the diagnosis and initial management of common primary care problems in pediatrics and obstetrics generally follows the topic sequence in other courses. Other issues unique to pediatrics and obstetrics are covered.

MEDEX 458/558 – Behavioral Medicine II (2 credits)
Continuation of MEDEX 457/557. This course provides in-depth coverage of common emotional problems seen in primary care. Topics include children's issues, sexuality, sexual assault, domestic violence, anxiety, behavior modification and negotiation training.

MEDEX 460/560 – Principles of Patient Management I (3 credits)
This course teaches a systematic approach to patient management applicable to a primary care setting. The course is devoted to drug therapy and its administration. Organ-system approach generally matches topic sequence of MEDEX 454/554.

MEDEX 468/568 – Emergency Medicine I (2 credits)
This course provides an approach to the diagnosis and management of common emergency conditions for primary care physician assistants. Topics include initial trauma assessment, multiple trauma to include head and abdominal trauma, shock, ENT & dental emergencies, orthopedic emergencies, psychiatric emergencies, ophthalmic emergency, spinal trauma and the acute abdomen.

MEDEX 471/571 – Professional Role Development II (1 credit)
Continuation of MEDEX 470/570. This quarter emphasizes knowledge, skills and attitudes for dealing with diverse population groups.

MEDEX 474/574 – Technical Skills II (1 credit)
Continuation of MEDEX 473/573. This quarter focuses on the interpretation of radiographs, which will be covered in lecture format. Students will be introduced to MRI, CT, ultrasound, chest radiographs, abdominal radiographs, and extremity radiographs. Workshops include the traumatic eye evaluation, the gynecological exam and casting and splinting.

Spring

MEDEX 455/555 – Adult Medicine II (7 credits)
Continuation of MEDEX 454/554. Through the multiple formats listed above, this course provides the same system-oriented approach to the diagnosis and initial management of common primary care conditions. The organ systems covered in spring include endocrinology, cardiology, dermatology, pulmonology and neurology.

MEDEX 459/559 – Behavioral Medicine III (2 credits)
Continuation of MEDEX 458/558 with the inclusion of topics such as alcoholism, addictions, personality disorders and problems related to aging.

MEDEX 461/561 – Principles of Patient Management II (3 credits)
Continuation of MEDEX 460/560. Organ-system approach generally matches topic sequence of MEDEX 455/555.

MEDEX 462/562 – Maternal & Child Health II (3 credits)
Continuation of MEDEX 456/556. The course continues a systems-oriented approach to the diagnosis and initial management of common primary care pediatric conditions. Topics include common respiratory, cardiac and dermatologic problems, and also issues of chronic illness in children.

MEDEX 469/569 – Emergency Medicine II (2 credits)
This course is a continuation of MEDEX 468/568. It provides an approach to the diagnosis and management of common emergency conditions for primary care physician assistants. Topics include chest trauma, cardiac emergencies which include; arrhythmias, acute coronary syndrome, vascular emergencies, environmental emergencies, pulmonary emergencies, GU and gynecological emergencies, endocrine emergencies, neurological emergencies and toxicology.

MEDEX 472/572 – Professional Role Development III (1 credit)
Continuation of MEDEX 471/571. This quarter emphasizes current issues in the health care delivery system. Topics include medical ethics, managed care, reimbursement, access and related issues.

MEDEX 475/575 – Technical Skills III (1 credit)
Continuation of MEDEX 474/574. During this quarter, the student will focus on 12-lead EKG interpretation which will be presented in lecture format. Spring workshops include suturing, the male GU exam and orientation to the operating room.

Second Summer (MCHS students only)

MEDEX 588 – Investigative Skills (5 credits)
Continuing changes in clinical practice, the scope of published health-related research, and ongoing changes to the PA profession require that the modern practitioner be able to locate, critically appraise, and implement current research findings. These skills are essential for practitioners to remain up-to-date with their profession. This course trains students in basic measurement, biostatistical and epidemiological concepts and techniques, and the research methods required to evaluate critically public health and biomedical research findings. Through a series of lectures targeting specific skills, practical exercises using current public health and biomedical research, and online group discussions, students will acquire skills allowing them to review and evaluate current research findings and apply supportable findings to practice.

Focused Study Course (5 credits, students will select one of the following options)
The focused study course will follow a small-group seminar design that allows students to select an area of special interest. The various sections will share a common theme of providing high quality care within healthcare systems, but will diverge in focus and application. Students may select only one subject focus, and the different subject sections run concurrently. The course meets several times during the initial two weeks of summer quarter, which are on campus. Subsequent weekly online meetings with assigned work will complete the quarter. This course will also equip students with the

tools to identify an appropriate subject-related capstone project idea of reasonable scope, and may impact site selection for one of the clinical rotations.

MEDEX 540 Healthcare for Rural and Medically Underserved Populations: This course will examine the nature and severity of disparities in health care access and delivery to rural and urban underserved populations. By comparing and contrasting the issues surrounding delivery of care to these two populations we gain a more complete picture of the systemic issues that inhibit equitable access to care for all. Students will be challenged to consider these issues from the perspective of policy-makers as well as from the perspective as clinicians.

MEDEX 541 Public Health and Preventive Medicine: This course will explore the principles, systems and practices of public health and preventive medicine at the local, state and national levels. The intent will be to compare and contrast the practice of treating a population versus a single patient. Students should also recognize the breadth of health professions and how the interdisciplinary teams in which they work provide the structure for public health and preventive medicine at all levels of health care.

MEDEX 542 Academic Medicine and Specialty Practice: Material will include faculty skill development, tools to thrive in an academic environment, interdisciplinary collaboration between primary care and specialty disciplines, and specialty practice at an academic medical center.

MEDEX 543 Global Health: Material will include international healthcare systems, international models of healthcare professions, disease processes and management tools in developing countries, healthcare in areas experiencing armed conflict, promoting health and managing disease across borders, cultural competency, and national and international government and agency policy-making and its impact on care, quality and access.

MEDEX 581 – Capstone Project I (3 credits)
Among the requirements for the master's-level PA program is a Capstone Project. Students will be expected to produce a finished product of sufficient depth and analytic rigor to demonstrate the independent thought appropriate to clinical master's-level work. Each student's Capstone Project will relate to his or her focused study area. Students will work on their project over five quarters, beginning in the summer between the first (didactic) and second (clinical) years of the PA curriculum. Students will plan and begin their project with input from faculty advisors.

Year 2: Clinical Year

MEDEX 463/563 – Clinical Clerkships I (19 credits)
MEDEX 465/565 – Clinical Clerkships II (19 credits)
Rotating clerkships offer four-week clinical experiences in a range of institution-based or specialty practice settings offered over two academic quarters. Required clerkships include inpatient internal medicine, general surgery, behavioral medicine, emergency medicine, a required experience in a medically underserved setting and an elective. Each clerkship includes seminars, patient logging, board review questions and self-study in combination with concentrated clinical experience. Specialty rotations are intended for exposure, not mastery. During clerkships, student progress is monitored through the use of various tools including evaluations by clinical instructors,

assignments patient logs, telephone/email communication, and site visits as needed. There is periodic testing to assess student progress. Offered credit/no credit only.

MEDEX 466/566 – Family Practice Preceptorship I (19 credits)
MEDEX 467/567 – Family Practice Preceptorship II (19 credits)
Preceptorship is considered to be the 'core' MEDEX clinical experience in primary care. Preceptorship is conducted under the supervision of a family practice physician and may involve experiences with other physicians and physician assistants. Students are trained to deal with common primary care problems. Both the student and preceptor are educated in utilization and supervision of the physician assistant in practice. Students keep records of patient encounters and complete a variety of written and community-based assignments in addition to their clinical encounters. The preceptorship is 16 weeks in length but may be extended in certain cases to permit a student to reach required performance levels. The educational objectives of preceptorship are: 1) to expand on the knowledge and skills acquired during the didactic phase with regard to the diagnosis and management commonly encountered primary care problems; 2) to become familiar with office management, documentation and administrative procedures; 3) to learn to function as an effective primary care team member and 4) to meet other objectives specified by the individual practice. All students will receive at least one full-day site visit by a MEDEX faculty member during this experience. Offered credit/no credit only.

MEDEX 582, 583, 584, 585 – Capstone Project II-V (MCHS students only; 1 credit each: autumn, winter, spring; 5 credits summer)
During the fall, winter, and spring quarters while working in their clinical rotations, students will continue with one-credit per quarter online Capstone courses. During this time, they will work on their projects and complete the written report. The fifth and final quarter will be in the last summer of the program. During this time, students will present the project in either oral presentation or poster session format.

AN INTRODUCTION TO CLERKSHIPS

The faculty of MEDEX Northwest welcomes you as a clinical preceptor in our educational program. We look forward to working with you and are sure that the experience will be mutually beneficial. We know you share our goal of providing a high-quality educational experience for MEDEX students.

The MEDEX Northwest Physician Assistant Program at the University of Washington offers a two-year curriculum designed to train individuals with previous health care experience in history-taking, physical diagnosis, patient management and health education. The Accreditation Review Commission on Education for Physician Assistants (ARC-PA) accredits our program. Applicants must meet both academic (college-level science and English courses) and clinical experience (minimum of 4,000 hours of patient contact) prerequisites. MEDEX students come from diverse backgrounds including EMTs, paramedics, nurses, community heath aides, surgical technicians, and military medics or corpsmen. The average age of the students is 35, and all are beginning a second career, having spent 3–5 years or more in an allied health profession.

Our formal training program includes one year of didactic instruction in anatomy and physiology, physical diagnosis, pathophysiology, pharmacology, *etc*. Instruction is provided by a variety of health care professionals including private practice physicians, pharmacists, practicing PAs and university-affiliated medical staff in addition to our core faculty. Students in the master's-level program also take courses in basic biostatistics and a special focused topic of study.

The second year involves structured rotations in various medical and surgical subspecialties and a longer primary care preceptorship where students work with a family practitioner in an outpatient clinical setting. There are also several weeks of orientation, examination and board review activities. Master's-level students work on a graduate-level capstone project throughout the clinical phase. The clinical year runs from September through August.

During the clerkship rotations, we require students to spend four weeks each in emergency medicine, ambulatory medicine (a variety of specialty electives is available), general surgery, behavioral medicine and inpatient medicine as well as in a site that serves medically underserved populations. The clerkships are designed with the intent to give students direct 'hands-on' patient contact under the supervision of the clinic or staff physician(s) or PA(s). We strongly encourage the involvement of staff PAs and nurse practitioners in providing clinical instruction to the students.

The students are provided with professional liability coverage through the University of Washington's Office of Risk Management. Our accreditation agency and liability coverage require us to have all training sites sign an affiliation agreement and a preceptor data form that formalizes the relationship between the university, the preceptor and the site.

The primary objective of the students during a clerkship is to receive supervised direct patient contact and medical management instruction designed to promote and enhance their clinical skills. The ideal clerkship situation would allow the student to do the following.

1. Interview the patient and obtain the pertinent medical history.
2. Perform the appropriate physical examination.
3. Present his or her findings to the preceptor.
4. Formulate a diagnosis and assessment with substantial input and teaching from the preceptor.
5. Decide on a plan of therapy that integrates the student's level of knowledge with the preceptor's clinical experience.
6. Write or dictate appropriate notes in the medical record to be reviewed and countersigned by the preceptor.
7. Function effectively as a member of the clinical team, appreciating the unique roles and strengths of other team members.

The degree of student involvement in the practice is determined by the type of practice, the demands of the patients, the student's skill level and, ultimately, the discretion of the supervising physician. Our experience has shown that a student who is allowed only to follow the physician without being able to perform clinical activities will achieve a no more than a minimal improvement in his or her clinical knowledge and understanding of disease processes. We require that a student evaluation form be completed and returned to MEDEX at the end of each clerkship.

We hope that the opportunity to teach is as fun and challenging for the preceptor as it is for the student. We also hope that the time and effort devoted to teaching will be balanced by the satisfaction of seeing the student become increasingly responsible for some of the routine tasks of providing medical care as the student reaches the end of the rotation with improved clinical skills. We thank you for your interest and efforts in providing clinical education to these students.

THE CLINICAL CLERKSHIP

I. General Goals

The Clinical Clerkship rotations (MEDEX 463/563 and 465/565) are designed to train the physician assistant to do the following.

1. Assess, diagnose and manage common acute problems and chronic primary care problems across the life-span.
2. Provide preventive health and health maintenance listed in national objectives.
3. Integrate him- or herself with other members of the health care team.
4. Establish medical practice standards.
5. Utilize evidence-based principles as part of a physician–PA student team.
6. Record and communicate medical data in an organized, intelligent process.
7. Identify role limitations and indications for referral and consultation.
8. Develop skills and habits necessary to life-long learning.
9. Provide compassionate, culturally competent health care to all patients.
10. Develop professionally in the role of a PA.

II. Responsibilities

A. Preceptor's Responsibilities

1. Provide a physical location with adequate clinical space and, ideally, computer and Internet access. Provide or help to arrange a variety of patient encounters necessary for a primary care–focused learning experience for the student.

2. Provide an adequate number of hours (clinic hours should be comparable to the preceptor's standard, full-time work-week) for the student to perform clinical activities in the practice site. During this time the preceptor or a designated alternate must be available for supervision, consultation and teaching.

3. Supervise, demonstrate, teach and observe the student in clinical activities in order to develop the student's skills and to ensure proper patient care.

4. Review and countersign student charting (or have designee do so).

5. Delegate gradually increasing levels of responsibility to the student for clinical assessment and management as the student's skills develop.

6. Notify the program promptly should any problems arise. It is the program's intention to have a completely open faculty-colleague relationship with the preceptor faculty. Should problems arise, early notification of the MEDEX clinical office (206-616-4001 or medexsr@u.washington.edu) will result in early problem-solving without diminishing the training experience for the student and without putting an onerous burden of responsibility on the preceptor.

7. Schedule time (the program recommends at least one hour per month for preceptorships and more frequently for clerkships) to review objectives with the student in order to identify areas of concern and provide specific experiences for the student to resolve any potential problem areas, *i.e.*, appropriate readings, supplemental experiences or observation and completion of student evaluations.

8. Allow the student to utilize the problem-oriented medical record system notation including problem lists, medication lists and flow sheets in record-keeping.

9. Participate in the evaluation of the student's clinical skills and medical knowledge-base through the following mechanisms.
   - Provide direct supervision, observation and teaching in the clinical setting.
   - Offer encouragement and support of student oral case presentations.
   - Discuss issues with faculty as appropriate to evaluate the student's progress and to assist the student's learning process. (If a site visit is scheduled, set aside 30 minutes to facilitate this.)
   - Review and countersign student charts, progress notes and history and physical write-ups on patients seen.
   - Complete the Final Evaluation, which assesses student performance over the entire rotation, review with the student and submit to the program for final grading purposes.

10. Support the student in completing the electronic patient log.

11. Support the student in completing online examinations and Board Review Questions as assigned. When appropriate, this support may be provided in the form of dedicated computer time in the office.

12. Oversee the student's compliance with HIPAA-related privacy expectations.

13. Facilitate relations between this PA student and the office staff in the practice site, as well as other health professionals in the medical community.

B. <u>The Program's Responsibilities</u>

1. Orient the preceptors and students to the structure of the clinical rotation through preliminary site visits and student counselling.

2. Serve as a resource in developing the PA role in a specific practice setting. The program is prepared to facilitate the introduction of the PA to the community in general and the medical community specifically.

3. Provide malpractice coverage for the student during all clerkships.

4. Maintain regular contact with the student in order to anticipate any problems before they arise and provide the student with a supportive network outside the clinical site.

5. Provide on-going educational opportunities, final exam testing experiences and board review activities.

6. Maintain an open dialogue with preceptors and students about the progress of each clerkship.

7. Provide evaluation tools to the preceptor and student to facilitate assessment and future planning in the preceptor site.

8. Provide information regarding the process of registration and licensure at the completion of the program.

C. Students' Responsibilities to the Preceptor, Site and Patients

1. Students will telephone the precepting clinician two weeks in advance of beginning the clinical assignment to verify the arrangements.

2. Students will maintain office hours that have been negotiated with the preceptor and communicated with office personnel. Students should realize that the scheduling of patients and the scheduling of the preceptor's time are an important consideration. Be sensitive to the pressures on the preceptor.

3. Have discussions with and update the preceptor regularly on progress toward meeting the program's objectives and assignments. Schedule meeting(s) as appropriate with the preceptor for completion and discussion of evaluation form(s).

4. Inform the preceptor regularly of student needs. This includes identifying where the student 'is' and 'ought to be' in specific clinical requirements and clinical skills.

5. Show sensitivity to the wishes of the patients and their willingness to share confidences or to have a student be partially responsible for their care.

6. Be aware of and apply HIPAA regulations regarding the privacy of patients' confidential information (see http://www.hhs.gov/ocr/hipaa).

7. Be aware of the way in which the preceptor deals with his or her patients. The student may not wish to adopt the same attitudes and behavior toward the patient; however, if it appears to be an area of potential conflict, it should be discussed before a major problem develops.

8. Complete charting each day before going home.

9. Some preceptors will assign reading lists, exams or projects specific to the site. Complete these preceptor assignments along with the program's assignments.

10. Be appreciative of the office staff.

11. Provide the very best care you can for the patients, which includes saying, 'I don't know, I'll find out' or 'I want the doctor to check this.' At the same time, each student should assert his or her proven skills to the fullest.

12. If conflicts arise, we expect students to attempt to discuss them and resolve them with the preceptor or staff to the best of their ability.

D. Students' Responsibilities to the Program

1. Inform the MEDEX office of unresolved issues immediately.

2. Attend all Review Weeks and Graduation Week activities as required.

3. Check email every day (within each 24-hour period).

4. Enter patient logs daily.

5. Plan clinical experience time; set your rotation schedule with your preceptor.

6. Complete and submit assignments as required by the program and by the preceptor in a timely manner to ensure delivery on or before due date. These will reflect the program's expectations and quotas for a competency-based clinical experience. Specific reading, writing, and/or checklist assignments will be required for each rotation. Students should make copies for their own files before sending assignments to the program. Specific due dates are listed for most assignments. If no specific due date the assignment is due one week after rotation.

7. Complete online testing requirements as assigned. Ask your preceptor in advance if you believe you will need consideration for dedicated time and/or space for these exams.

8. Complete Board Review Questions by the assigned deadlines.

9. Plan for Campus Weeks and Graduation Week. The time commitment will be five days after the one-month rotation that follows the preceptorship. (See clinical year schedule.) Attendance at these activities is mandatory.

10. State and national conference attendance is a privilege and students must be in good program standing and receive program permission in advance from the Program Director to attend. Refer to the Student Handbook chapter on Contributions to the PA Profession for additional details.

E. Students' Responsibilities to Themselves

1. **Students are responsible for their own clinical progress** and for making their needs known to the preceptor and to the program.

2. Schedule adequate time for readings, intensive study, board preparation and patient log completion.

3. Schedule weekly leisure time in order to maintain a healthy balance with your school responsibilities.

4. Keep all lines of communication open among yourself, family, support groups, your preceptor and the program.

5. Keep the Clinical Portfolio up-to-date throughout the year.

6. Review the instruction cards: *Procedure following exposure to blood/body fluids* and *Contacts following occupational exposure to blood/body fluids*.

III. Monitoring the Clerkship

A. Faculty Advisement

Each preceptor–PA student team is assigned a MEDEX faculty member as an advisor. This connection permits the faculty to maintain regular contact with the clinical site.

B. Student Clerkship Assignments

Complete the required assignments as listed in the student manual. These will reflect the program's expectations and quotas for competency-based clinical rotations. Students should make copies of all assignments for their own files before sending them to the program.

1. Each rotation will have specific assignments.

   Cover sheets. Each assignment requires a cover sheet. You will find specific cover sheets in the section for assignments in the student manuals.

   On-line exams. All students are expected to participate in online testing. The schedule for these exams is posted on Moodle.

2. Patient Charting

   All write-ups are to be evaluated and counter-signed by the preceptor or an appointed designee. This exercise permits monitoring of teaching and performance in the practice. Recognizing that students will select write-ups that they consider to be among their best, the upper limits of the quality of the student's practice are assessed. The ability to focus the write-up appropriately, the level of competency in using the problem-oriented medical system and written presentation skills are also reviewed. If problems are noted in any of these areas, the faculty member will suggest strategies for improvement.

3. Patient Log

   Students will complete electronic patient logs daily containing HIPAA appropriate information on every patient seen. The patient log allows the faculty to evaluate the student's training and make recommendations for additional educational experiences where appropriate. The progress of the teaching at the clinical site can be compared with the original objectives included in the preceptor packet and discussed with the preceptor, including the diversity of patients seen plus the amount and type of

preceptor contact with the student. Logs should be reviewed remotely via the web regularly to ensure appropriate progress. The usual method of transmission will be via Internet upload.

4. Additional Assignments

Additional assignments may be assigned by the preceptor or program that may include journal review, written papers, additional reading, *etc*.

C. Evaluations

Although teaching and learning plans, electronic patient logs and write-ups are designed as tools to standardize and monitor the educational process of clinical training, they are also part of the information used to evaluate students and their development into the professional role. The evaluation activities described below are utilized by the program for the purpose of monitoring as well.

Information from all evaluation efforts and completion of assignments are the basis for the decision to pass the student, extend the rotation, place the student on academic warning, or probation, or, in rare instances, dismiss the student from the program. These performance evaluations become a part of the student's permanent record.

1. Evaluation by the Preceptor

Final Evaluation. This is an evaluation of the student's cumulative performance, which includes an assessment of the professional behaviors and attitudes of the student as well as his or her clinical skills. It assesses the student's performance in-depth and states whether the preceptor believes the student has 'passed' or 'failed' that clerkship rotation.

Faculty Development Evaluation. An evaluation form specific to Faculty Development rotations is provided, and should be used in place of the practice-oriented clerkship evaluation form in these settings.

2. Evaluation by the Student

Students will complete an evaluation of the site at the end of the each clerkship rotation.

3. Online Exams and Board Review Questions

Online Testing. Students are required to participate in online exams at specific times throughout the clinical phase. These are multiple choice tests designed to strengthen as well as assess the student's knowledge-base in the subject areas on the PANCE.

Board Review Questions. Students are required to participate in the weekly Board Review Questions (BRQs). These are multiple choice review questions designed to assist students in studying for the NCCPA exam.

4. Review Weeks

   Students are required to return to the MEDEX program for OSCE testing and medical education update in February-March, May and August. Testing will consist of problem-solving, assessment of assignments, and physical examination skills as appropriate, as well as other testing and evaluations as announced.

5. Other Evaluations

   Other evaluations may be added as necessary. The program reserves the right to site visit students in order to assess their progress in clinical training.

CONTINUING MEDICAL EDUCATION CREDITS

Thank you for working with us to educate tomorrow's physician assistants. Clinical rotations depend on your participation. We hope that you will find the precepting experience stimulating and rewarding. However, there are more tangible perks as well. As a preceptor you are eligible to apply for CME credits.

Physician (Source: Washington State Medical Quality Assurance Commission)

The Washington State Medical Quality Assurance Commission requires 200 credit hours of continuing education every 4 years. One clock hour is equal to one credit hour for the purpose of satisfying the 200-hour continuing medical education requirement.

Physicians in the state of Washington are eligible to apply for Category III (Medical Teaching) continuing medical education credit. A maximum of 80 credit hours are allowed in this category for each 4-year period. We calculate that you will have engaged in more than that number of teaching hours by the time you have completed your precepting responsibilities.

> **Category III: Teaching of physicians or other allied health professionals.** A maximum of 80 credit hours may be earned for serving as an instructor of medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program if the hospital or institution has approved the instruction.

If you have questions, please contact the Washington State Medical Quality Assurance Commission at (360) 236-2750.

Other WWAMI states

Alaska State Medical Board (907) 269-8163
Montana Board of Medical Examiners (406) 841-2204
Idaho State Board of Medicine (208) 327-7000
Wyoming State Board of Medicine (307) 778-7053 or (800) 438-5784

Other western states

Medical Board of California (800) 633-2322 or (916) 263-2382
Hawaii Medical Board (808) 586-3000
Nevada State Board of Medical Examiners (775) 688-2559
Oregon Medical Board (971) 673-2700 or (877) 254-6263

Physician Assistant–Certified (Source: AAPA and NCCPA)

The NCCPA requires 100 credit hours of continuing education every 2 years. One clock hour is equal to one credit hour for the purpose of satisfying the 100-hour continuing medical education requirement.

Physician assistants are eligible to apply for Category II CME hours. Category II hours may be earned by—among other things—participating in a medically-related, voluntary self-learning activity such as journal reading, medical text reading or precepting.

If you have questions, please contact the National Commission on Certification of Physician Assistants at (678) 417-8100.

CLINIC OR HOSPITAL PRIVILEGES FOR A PHYSICIAN ASSISTANT STUDENT

A frequently asked question from precepting sites is how a clinical site should document a student's clinical site privileges. This is a sample of how one ***small-town community hospital*** handles credentialing of PA students.

Recommended Guidelines Regarding Physician Assistant Students

One of the focuses of the hospital is to provide clinical experiences for physician assistant students in a rural setting. Credentialed medical staff physicians and physician assistants or nurse practitioners at the hospital agree that the following guidelines must be adhered to in order to ensure the safety and well-being of the patients served, to maintain the legal integrity of the facility itself, and also provide an atmosphere rich in clinical experience for the students.

1. A file must be kept on each student who is precepted by a physician, PA or NP to include if applicable:
   a. a copy of liability coverage from the school or university attended,
   b. student *curriculum vitæ*,
   c. documentation of immunization compliance
   d. privileges letter from school verifying student status and rotation dates.

2. The amount of direct supervision needed for each student will be determined by the individual precepting the student, and it will be the sole responsibility of the preceptor to assure the safety of the patient through repeated exams, review of test results, verbal confirmation regarding the patient or other means as indicated.

3. It will be the responsibility of the preceptor to obtain and secure with appropriate hospital staff and PA program staff the required documents mentioned above prior to the arrival of the student.

4. Medical Staff Rules and Regulations will be consulted and followed regarding any activity performed, assisted or observed by the student.

5. Patient courtesy guidelines will be followed regarding patients' rights to refuse the presence of the student.

6. Documentation by the student in the hospital setting will require co-signature appropriate to the level of the preceptor.

This is a sample of how one ***medium-sized community hospital*** handles credentialing of PA students.

Rules for Participation of Physician Assistant Students

Objectives

The medical staff of the hospital wishes to encourage the participation of physician assistant students. These rules are intended to facilitate physician assistant student participation. The rules recognize the following levels of participation.

- ***Observational***
  A member of the staff may request permission for a physician assistant student to accompany him or her in the hospital to observe the physician in his or her daily work. Such observation may extend to any area of the hospital. In order to facilitate this level of involvement, requirements are minimal. The sponsoring medical staff member assumes full responsibility for the student. This level of involvement is most appropriate for students early in their training, whose experience will be brief and limited.

- ***Active***
  Physician assistant students who are engaged in their clinical training and who are participating with their attending(s) and/or preceptor(s) in care that involves the hospitals or any of their attendant services must meet more stringent requirements.

  - An on-going relationship between the University of Washington MEDEX Northwest Division of Physician Assistant Studies and the hospital exists with regard to specific, on-going and pre-approved rotations, which are a part of the regular curriculum offered through the program.

  - The medical staff and the hospital must be assured that any student who has direct patient contact is covered for liability that may arise as a result of that contact. Typically, such coverage is extended by the university PA program to the student when the experience is recognized by the student's school and is specifically approved. The student is responsible for obtaining such assurance from his or her school prior to involvement in patient care.

I. Observational Participation

A. Physician Assistant students shall be permitted to accompany preceptors within the hospitals.
B. The preceptor must have Active or Courtesy Staff status, and be in good standing.
C. The student will wear his or her nametag and be introduced as a student.

D. The student is not allowed to have any conversation or contact with patients in the hospital, except as attended by the preceptor.
E. Under no circumstances shall the student be involved in the performance of any procedure.

F. Admission to restricted areas of the hospital (*e.g.*, Surgery, ICU, CCU) shall be by the invitation of the charge nurse of the unit at the time of the visit, at the request of the sponsoring staff member.
G. Students functioning in an observational capacity are ***not*** permitted to make entries into the hospital medical record.

II. Active Participation

A. Students who will have any unattended patient contact or make entries into the medical record are active participants. Typically, unattended contact is permitted for the purpose of obtaining a history from and performing examination of the patient.
B. If the student's role places him or her on an identified inpatient unit, he or she will be introduced to the charge nurse.
C. Student history and physical examination, chart notes and orders must be reviewed and countersigned by the preceptor. All orders must be countersigned or given verbal approval by the preceptor prior to being carried out by nursing staff.
D. The student must wear a name tag and introduce him- or herself to the patient and hospital staff as a physician assistant student.
E. The student is permitted to perform procedures only under the direct supervision of the preceptor.
F. The student is allowed to second-assist only at surgery.

III. Contact by a Non MEDEX Student or Another Physician Assistant Program

Non MEDEX Northwest students and other Physician Assistant programs should not be contacting preceptors directly looking for clerkship/preceptorship placements. If this happens please contact the MEDEX Northwest Clinical Office.

MEDEX Clinical Year 2014-15

		P1	P2
2014	Sept 15 to Sept 19	Transition Week	
	Sept 22 to Oct 17	Preceptorship	Clerkship 1
	Oct 20 to Nov 14		Clerkship 2
	Nov 17 to Dec 12		Clerkship 3
	Dec 13 to Jan 4	Winter Break	
2015	Jan 5 to Jan 30		Clerkship 4
	Feb 2 to Feb 6	Campus Week #1	
	Feb 9 to Mar 6	Clerkship 1	Clerkship 5
	Mar 9 to Apr 3	Clerkship 2	Clerkship 6
	Apr 6 to Apr 10	Spring Break	
	Apr 13 to May 8	Clerkship 3	Preceptorship
	May 11 to Jun 5	Clerkship 4	
	Jun 8 to Jun 12	Campus Week #2	
	Jun 15 to Jul 10	Clerkship 5	
	Jul 13 to Aug 7	Clerkship 6	
	Aug 10 to Aug 14	Tacoma/Anchorage Graduation Week	
	Aug 17 to Aug 21	Seattle/Spokane Graduation Week	

Questions regarding this schedule should be directed to Tony Skaggs in the Clinical Office at skaggs2@uw.edu or (206) 616-4001.

UNIVERSITY OF WASHINGTON

OFFICE OF RISK MANAGEMENT

EVIDENCE OF PROFESSIONAL LIABILITY COVERAGE

Covered: University of Washington – **Medex Northwest**

Term: 7/01/2011 through 06/30/2016

Limits: Coverage is unlimited per occurrence and in the aggregate

Policy Number: Not applicable; this is a statutorily self-insured program

Form: Occurrence

Conditions: Coverage applies to the negligent acts or omissions of the University of Washington and its employees, students, and agents acting in the course and scope of their University duties. The term "agent" includes volunteers to authorized University programs.

Contact: Garrett Stronks at (206) 543-3659, fax (206) 543-3773

Date Issued: September 23, 2013

22 Gerberding Hall Box 351276 Seattle, Washington 98195-1276 (206) 543-3659 FAX: (206) 543-3773
gdawg@u.washington.edu

MEDEX Northwest
Division of Physician Assistant Studies
4311 11th Ave NE, Ste 200
Seattle WA 98105
(206) 616-4001 office
(206) 616-3889 fax

Rotation Dates:_____
Due: Last Week of Clerkship
(*Complete Monday, submit by Friday*)

CLERKSHIP: FINAL EVALUATION OF STUDENT BY PRECEPTOR

Student: _____ **Site or Clinic:** _____

Preceptor: _____ **Type of Rotation:** _____

1. KNOWLEDGE OF BASIC MEDICINE

☐ Not observed.	☐ Knowledge is sketchy. Has difficulty recalling basic knowledge.	☐ Occasionally unable to recall basic knowledge and relate it to cases.	☐ Is able to recall basic knowledge and relate it to cases.	☐ Recalls broad base of knowledge, which is readily available to relate to cases.

Remarks: _____

2. HISTORY-TAKING SKILLS

☐ Not observed.	☐ History is incomplete or inaccurate; fails to elicit important information and describe findings.	☐ History is generally complete and accurate but occasionally fails to elicit important information and describe findings.	☐ History is complete and accurate; elicits important information and is able to describe findings.	☐ History is comprehensive. Elicits important information and is able to specify and follow up on findings.

Remarks: _____

3. PHYSICAL EXAMINATION SKILLS

☐ Not observed.	☐ Exam is incomplete. Fails to follow logical sequence. Deficient technical qualities.	☐ Exam is generally complete. Occasionally fails to follow logical sequences. Minor technical difficulties.	☐ Exam is thorough. Follows logical sequences. Technically reliable and smooth.	☐ Exam is thorough and precise. Follows logical sequences even in difficult cases. Technically efficient and sound.

Remarks: _____

4. Laboratory and Test Skills

☐ Not observed.	☐ Deficient knowledge of routine tests. Fails to demonstrate knowledge of special diagnostic tests. Has difficulty interpreting results.	☐ Occasionally lacks knowledge of routine tests. Sometimes fails to demonstrate knowledge of special diagnostic tests. Occasionally has difficulty interpreting results.	☐ Demonstrates knowledge of routine and special diagnostic tests. Interprets results.	☐ Demonstrates broad knowledge-base of routine and special diagnostic tests. Interprets results correctly.

Remarks: _____

5. Integrative Skills

☐ Not observed.	☐ Fails to integrate data. Unable to identify problems and priorities. Frequently overlooks additional data requirements regarding cases.	☐ Usually integrates data. Identifies problems and priorities though sometimes overlooks additional data requirements regarding cases.	☐ Integration of data is complete. Understands and identifies problems and priorities. Correlates additional data requirements regarding cases.	☐ Integration of data is comprehensive. Understands and identifies problems and priorities. Promptly correlates additional data requirements regarding cases.

Remarks: _____

6. Written Skills

☐ Not observed.	☐ Poorly prepared write-ups. Includes irrelevant information; fails to provide relevant data. Fails to make progress notes.	☐ Write-ups need some improvement. Sometimes excludes relevant data. Progress notes are occasionally missing or late.	☐ Write-ups concise and orderly. Complete and relevant information is included. Problems and progress are noted promptly.	☐ Write-ups outstanding (well-written, precise and thorough). Problems and progress are pinpointed and noted promptly with adequate explanations.

Remarks: _____

7. Oral Skills

☐ Not observed.	☐ Cannot explain or summarize data. Presentation of information unorganized and confused.	☐ Tries to explain or summarize data, but has some difficulty. Presentation of information is occasionally confusing.	☐ Communicates effectively. Able to explain and summarize data without difficulty. Presentation of information organized and complete.	☐ Polished communication skills. Able to explain and summarize data completely and concisely. Presentation of information is orderly and concise.

Remarks: _____

8. Management Skills

☐ Not observed.	☐ Fails to implement preceptor's instructions. Therapeutic program is incomplete or inaccurate. Follow-up is lacking.	☐ Generally implements preceptor's instructions. Therapeutic program usually complete and acurate, but treatments sometimes overlooked. Follow-up sometimes lacking or erratic.	☐ Implements preceptor's instructions. Therapeutic program is complete and accurate. Treatments are included. Follow-up is implemented.	☐ Implements preceptor's instructions promptly and efficiently. Therapeutic program comprehensive. Treatments precise. Implements follow-up and can suggest alternative plan if necessary.

Remarks: _____

9. Judgment

☐ Not observed.	☐ Fails to make appropriate medical judgments. Deficient in timing and coordination based on data obtained.	☐ Sometimes has difficulty making appropriate medical judgments. Minor problems in timing and coordination based on data obtained.	☐ Makes appropriate medical judgments. Timing and coordination based on data obtained is smooth and proper.	☐ Makes correct medical judgments. Timing and coordination based on data obtained is efficient and precise.

Remarks: _____

10. Interaction with Patients

☐ Not observed.	☐ Lacks communication skills. Cannot adequately explain things to patients. Fails to listen to patients.	☐ Attempts to explain things to patients, but occasionally has difficulty. Usually listens to patients.	☐ Communicates effectively. Gives appropriate explanations. Listens attentively to patients.	☐ Communication is polished. Makes extra effort to give explanations. Listens attentively even when confronted with difficult patients.

Remarks: _____

11. Interaction with Other Health Professionals

☐ Not observed.	☐ Fails to cooperate with other health professionals. Does not recognize own limitations and fails to respect others' professional roles.	☐ Generally cooperates with other health professionals. Occasionally fails to recognize own limitations. Usually respects others' professional roles.	☐ Cooperates with other professionals. Recognizes own limitations and respects others' roles.	☐ Makes extra effort to cooperate with other health professionals. Recognizes own limitations, respects as well as complements others' professional roles.

Remarks: _____

12. PROFESSIONAL BEHAVIORS	Unsatisfactory (specify in Sec. 13)	Satisfactory	Outstanding
a. Dependability	☐	☐	☐
b. Initiative	☐	☐	☐
c. Integrity	☐	☐	☐
d. Appearance	☐	☐	☐

Remarks: _____

☐

☐ a. Incomplete work: unfinished chart work, assignments not done.
☐ b. Absenteeism: repeated absence from activities, lateness, not available for rounds, conferences.
☐ c. Poor attitude: negativism, chronic complaining, lack of enjoyment in work.
☐ d. Sloppy or imprecise work: insufficient attention to quality, need to recheck database or orders.
☐ e. Unresponsive to correction: when deficiencies are pointed out, doesn't correct them; makes same errors repeatedly.
☐ f. Impracticality: impractical plans and suggestions, dangerous orders, off on tangents.
☐ g. Inefficiency: works hard, gets nothing done.
☐ h. Doesn't know what's going on: needs to be spoon-fed daily orders, progress notes.
☐ i. Timid, insecure: performance may be affected by lack of self-confidence.
☐ j. Doesn't know own limitations: not cautious enough, proceeds on own without checking with appropriate person; overestimates abilities.
☐ k. Inability to prioritize and manage multiple tasks.
☐ l. Unable to deal with stress and complexities of the clinical situation.
☐ m. Other: _____

☐ FAIL* ☐ BORDERLINE* ☐ PASS ☐ EXCEPTIONAL PERFORMANCE

☐ *Would prefer verbal conference with student's faculty advisor. Please call preceptor at: _____

16. Did you discuss this evaluation with the student? ☐ No ☐ Yes

Signature of preceptor (required): _____ Date: _____

Signature of student (preferred): _____ Date: _____

MEDEX Northwest
Division of Physician Assistant Studies
4311 11th Ave NE, Ste 200
Seattle WA 98105
(206) 616-4001 office
(206) 616-3889 fax

Rotation Dates:_____
Due: Last Week of Rotation
(*Complete Monday, submit by Friday*)

FACULTY DEVELOPMENT

FINAL EVALUATION OF STUDENT BY FACULTY DEVELOPMENT MENTOR

Student:_____ Preceptor/Mentor:_____

The purpose of this rotation is to provide a variety of supervised experiences that will enable a physician assistant student to develop the basic skills necessary to become an effective junior faculty member in a PA program. These experiences will include administration and teaching in both didactic and clinical areas. Contact Linda Vorvick at (206) 616-4001 with any questions. Submission of a letter—with comments covering these topics—would be acceptable in lieu of this form.

The student was involved in the following (check and comment on all that apply)

ADMISSIONS

- ☐ Application process
- ☐ Interview process
- ☐ Selection process
- ☐ Other:_____

Comments:_____

_____

_____

TEACHING/DIDACTIC PHASE

- ☐ Develop an instructional module for PA students including the following
  - ☐ definition of an overall goal for the module
  - ☐ written objectives to enable students to attain goal
  - ☐ selection of reading assignment
  - ☐ preparation of lecture materials, *e.g.*, outline, audio-visual aids
  - ☐ presentation of lecture, using format of choice
  - ☐ development of an evaluation tool for module, *e.g.*, quiz, competency checklist
- ☐ Participate in the process of setting up clinics and workshops for didactic-phase students
- ☐ Appropriate interaction with students
- ☐ Other:_____

Comments:_____

_____

_____

Clinical Phase

- ☐ Work with the clinical coordinator
- ☐ Participate in approval site visits with a faculty mentor
- ☐ Participate with a faculty mentor in routine site visit of a student in preceptorship
- ☐ Other: _____

Comments: _____

_____

_____

Program Administration

- ☐ Meet with the program director
  - ☐ discuss program funding issues
  - ☐ review the accreditation history of the program
  - ☐ other _____
- ☐ Review the most recent self-study report and schedule a follow-up meeting to discuss the program's evaluation and planning process
- ☐ Attend at least one major administrative meeting with the program's director or administrator and discuss the meeting retrospectively with the director or administrator
- ☐ Other: _____

Comments: _____

_____

_____

Clinical Practice

- ☐ Atttend clinic with a faculty member to become familiar with the issues involved in integrating faculty and clinical practice
- ☐ Other: _____

Comments: _____

_____

_____

Other

Comments: _____

_____

☐ I would like to have a telephone conference with MEDEX faculty.

Signature of preceptor _____ Date _____
(required)

Signature of student _____ Date _____
(required)

GUIDELINES FOR INTEGRATION OF A PHYSICIAN ASSISTANT INTO THE PRACTICE

Practice and Community Preparation

When any new type of provider is added to the health care team, it is helpful to involve members of the clinic staff in planning and orientation. Our experience with practice and community preparation indicates that PAs are most successfully integrated into a new site when sufficient care is taken to involve all of the stake-holders.

With this premise in mind, we recommend that the preceptor and clinic management consider the following groups who will interact with the new provider.

1. Office Staff

   A general meeting of the entire office staff (nurse, business manager, lab technician, receptionist, *et al.*), held a few weeks before the PA arrives would be useful for answering questions and airing concerns. The following are some possible topics to cover.

   a. Why do you, as preceptor, find it beneficial to have a PA in the practice?
   b. What support is required of the staff to assist in transition?
   c. What will the PA's role and function be, *i.e.*, how will he or she be utilized?
   d. What will the physician-PA, physician-nurse and nurse-PA relationships be?
   e. Provide personal data, training, experience and other background of the PA.

   Regular meetings of the office staff—in which problems of scheduling, office procedure and role negotiation are discussed—could help to reduce the tensions that may accompany change.

2. Colleagues

   Local physicians should be contacted to provide them with information appropriate to your clinical site and the PA's anticipated role in your practice. Letters might be sent to all local physicians as a matter of courtesy. You may also wish to contact your regional or county medical societies.

3. Hospitals

   Local hospitals should be contacted to make arrangements that will allow your PA to participate in hospital-based activities as needed. Obtain information on their policies and practices and provide hospitals with information on how your PA might be involved in the care of your patients. Most hospitals have credentialing and privileging requirements.

4. Patients

   You may choose to post information sheets and flyers at the registration desk and in exam rooms that describe the background and skills of the physician assistant(s). Some clinics have included information about the new provider in a monthly billing update.

5. Newspapers

   Many clinics advertise the addition of the PA in the same fashion that they would market a new physician. Some community papers also welcome news releases announcing the new health care provider in the community. The MEDEX program is available to provide assistance in creating advertisements and press releases.

6. Other groups to involve

   a. local pharmacists
   b. local home health care or visiting nurse services
   c. nursing home staff
   d. civic clubs

GOVERNMENT AND PROFESSIONAL ISSUES

The following pages list some of the articles available on the AAPA web site (http://www.aapa.org).
The AAPA also has publications available for purchase.

All states have enacted laws and regulations authorizing PAs to practice medicine with physician supervision. In the District of Columbia, Guam and all 50 states, PAs are regulated by a licensing board whose regulations should be read in conjunction with the PA practice act.

One of the long-standing goals of the American Academy of Physician Assistants (AAPA) has been to assure that insurance companies and other third-party payers cover the medical services provided by PAs. Medicare and TRICARE pay for services provided by PAs in almost all practice settings, as well as for assisting at surgery. Many state Medicaid programs and private insurers also cover services provided by PAs.

Government Issues

- Summary of State Laws for Physician Assistants (Abridged)
- State PA Licensing Boards
- Summary Chart: State Statutory and Regulatory Requirements
- States that Authorize Physician Assistant Prescribing

Reimbursement Issues

- Medicare Policy Chart for PAs
- Medicare Coverage for PAs
- 'Incident To' Billing
- Medicare Coverage of Services Provided in Hospitals
- Medicaid Coverage
- State Medicaid Profiles
- Private Payer Profiles

Professional Practice Issues

- Guidelines for Ethical Conduct for the Physician Assistant Profession
- The Physician-PA Team
- The Role of Chart Co-Signature in Physician Supervising of Physician Assistants
- Physician Assistant Scope of Practice

PAs and Specialty Practice

- PAs in Allergy and Immunology Medicine
- PAs in Cardiology
- PAs in Dermatology
- PAs in Emergency Medicine
- PAs in Gastroenterology and Hepatology
- PAs in Nephrology
- PAs in Neurosurgery
- PAs in Obstetrics and Gynecology
- PAs in Occupational Medicine PAs: Promoting Employee Health
- PAs in Oncology
- PAs in Orthopedic Surgery
- PAs in Otolaryngology
- PAs in Pediatrics
- PAs and Radiology
- PAs in Surgery
- PAs and Anesthesiologist Assistants: the Distinctions
- PAs and Orthopedic PAs: the Distinctions

PAs and Hospital Practice

- Reduced Resident Hours Call for Creative Solution: Hire Physician Assistants
- PAs as Members of the Medical Staff
- Hospital Practice: Credentialling and Privileging
- Denial of Hospital Privileges: Antitrust Implications
- Guidelines for Amending Hospital Staff Bylaws
- Joint Commission Updates

Health Care Delivery Systems

- Independent Practice Associations: a Primer for PAs
- Medical Unions and PAs
- PAs as Medicaid Managed Care Providers
- Managed Health Care and Rural America

Employment and Business Resources

- Hiring a PA: the Benefits for Physicians and Practices
- Guide for New PA Employers
- Anatomy of a Contract
- Pre-Employment Checklist for PAs
- Employment Exit Checklist for PAs
- Business Resources for PAs

THE PHYSICIAN-PA TEAM

From the AAPA.
(http://www.aapa.org/uploadedFiles/content/The_PA_Profession/Federal_and_State_Affairs/Resource_Items/PI_PhysicianPATeam_v3.pdf)

The physician assistant (PA) profession was founded on—and remains committed to—the concept of team practice. Working in all medical and surgical specialties, physician–PA teams enhance coordination and quality of care. The physician-PA team is effective because of the similarities in physician and PA training, the PA profession's commitment to practice with supervision and the efficiencies created by utilizing the strengths of each professional in the clinical practice setting.

Physician Assistant Education — Training in the Medical Model

The relationship between PAs and physicians begins in PA school where physicians, PAs, and science professors provide instruction in a curriculum following the medical school model. PA students typically share classes, facilities, and clinical rotations with medical students. PA program applicants must complete at least two years of college courses in basic science and behavioral science as prerequisites to PA training.* This is analogous to premedical studies required of medical students. The average length of PA education programs is about 27 months.[1] Students begin PA programs with a year of basic medical science courses (anatomy, pathophysiology, pharmacology, physical diagnosis, *etc.*). Following the basic science and medical science classroom work, PA students enter the clinical phase of training. This includes classroom instruction and clinical rotations in medical and surgical specialties (family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine and psychiatry). Due to the comprehensiveness of the rotation schedule, PA students complete 2,000 hours of supervised clinical practice prior to graduation.[2]

Because they train using similar curriculum, training sites, faculties and facilities, physicians and PAs develop a similarity in medical reasoning during their schooling that eventually leads to standardized thought in the clinical workplace; PAs think like doctors.[3]

Commitment to Team Practice

The PA profession remains committed to the concept of the supervising physician–PA team. This is reflected in the American Academy of Physician Assistants' (AAPA) description of the profession: 'Physician assistants are health professionals licensed or, in the case of those employed by the federal government, credentialed to practice medicine with physician supervision.'[4]

Since AAPA is the national professional society for PAs, its guidelines reflect the philosophy of PAs in all specialties. Thus, the commitment to practicing as part of a physician-directed team is clearly stated in the AAPA policy on team practice: 'AAPA believes that the physician–PA team relationship is fundamental to the PA profession and enhances the delivery of high-quality health

care. As the structure of the health care system changes, it is critical that this essential relationship be preserved and strengthened.'[5]

Several other medical organizations have policies supporting team practice. In 1995 the American Medical Association adopted guidelines for physician–PA practice. The 10 guidelines describe the roles of the physician and the PA, including the following: 'The role of the physician assistant(s) in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.'[6]

The American Academy of Family Physicians (AAFP) also recognizes the value of team practice. AAFP policy states: 'The AAFP recognizes the dynamic nature of the health care environment and the importance of an interdependent team approach to health care that is supervised by a responsible licensed physician.[7]

Additionally, in 1998 the Pew Health Professions Commission completed a two-year study of the PA profession. In its 12 recommendations for PA deployment, the report supports the continuation of the traditional physician–PA team, and suggests its use as a model in an evolving system: 'The traditional relationship between PAs and physicians, the hallmarks of which are frequent consultation, referral and review of PA practice by the supervising physician, is one of the strengths of the PA profession. The characteristics of this relationship are also considered to be the elements of professional relationships in any well-designed health system.'[8]

The Physician-PA Team — Synergy in Clinical Practice

The physician–PA team supports efficient patient-centered health care. Because of this, all states, the District of Columbia and the majority of US territories allow physicians to delegate to PAs medical duties that are within the physician's scope of practice, the PA's training and experience, and state law. Such duties include performing physical examinations, diagnosing and treating illnesses, ordering and interpreting lab tests, assisting in surgery and caring for patients in hospitals and nursing homes. In all states, the District of Columbia, the Commonwealth of the Northern Mariana Islands and Guam, physicians may delegate prescriptive privileges to the PAs they supervise.

PAs have been incorporated into all practice areas, and numerous studies have found that the quality of care that PAs provide is comparable to that of physicians.[9-12] According to a study published in The American Surgeon in 2004: 'PAs have demonstrated their abilities to perform in supervised intensive care settings, general inpatient unit, and are a valuable adjunct in improving quality of patient care.'[13]

Not only is the quality of care similar between physicians and PAs, but levels of patient satisfaction are also similar. A study conducted from 1997 to 2000 assessing patient satisfaction in a large, metropolitan managed care organization (MCO) found that: 'Patient satisfaction with practitioner interaction, care access and overall experience on visits attended by PAs…was equivalent to, or slightly better than, that on visits attended by MDs in the primary care practices of this MCO.'[14]

Further, a nationwide study published in 2005 found that, regardless of provider, Medicare patients are generally satisfied with the quality of health care they receive.[15] Thus, when the physician–PA team effectively uses the skills of each provider, it then ensures appropriate, integrated care and high levels of patient satisfaction.

PAs also enhance health care coordination. They are responsible for the day-to-day care of patients, turning to their supervising physicians for cases requiring more advanced medical knowledge. In many primary care practices, the presence of PAs allows patients to be seen promptly, knowing that any routine problems will be handled effectively and that the expertise of the physician is available if needed. PAs are able to handle common patient complaints, follow-up visits and patient education and counselling. Physicians are then able to focus on complicated patient problems and allow appropriate time for their care.

In surgical practices, the presence of PAs enables surgeons to delegate the performance of preoperative histories and physical examinations, the ordering and compiling of necessary tests and part of the postoperative care. In addition, PAs are excellent assistants at surgery. The familiarity and experience of the physician–PA surgical team results in efficiency in the OR that can reduce operative and anesthesia times.

Physician–PA teams are also effective in medical and surgical subspecialty practices, where PAs perform examinations and procedures, order tests, provide follow-up care and help with the coordination of care for patients with complex illnesses. The AMA's Socioeconomic Monitoring System of approximately 4,000 practices found that 56 percent of group practice physicians and 39 percent of solo practice physicians employ non-physician providers, including PAs. According to the survey report, '[t]he data show that employing non-physician providers enhances physician productivity.'[16]

Not only do studies attest to the value of the physician–PA team, but so do physicians themselves. Writing in the journal Family Practice Management, a family physician describes the PA's role in the practice: 'The PA makes himself invaluable by smoothing the ebbs and flows of our daily workload… We wonder how any practice can thrive without one.'[17]

PAs remain committed to providing quality health care as part of a physician-PA team. To learn more about the PA profession and how PAs contribute to comprehensive patient-centered care, visit www.aapa.org.

References

1. Physician Assistant Education Association. (2007–2008). *Twenty-fourth annual report on physician assistant educational programs in the United States.* Alexandria, VA.
2. Association of Physician Assistant Programs. (1994–1995). *Eleventh annual report on physician assistant educational programs in the United States. Washington, DC.*
3. White G.L., Egerton, C.P., Myers, R., & Holbert, R.D. (1994). Physician assistants and Mississippi. *Journal of Mississippi State Medical Association,* 35(12), 353-357.
4. American Academy of Physician Assistants. (2009–2010). *Policy Manual.* Alexandria, VA.
5. *Ibid.*

6. American Medical Association. (2009). *Physician Assistants and Nurse Practitioners.* Policy H-160-947, from www.ama-assn.org/ad-com/polfind/Hlth-Ethics.pdf, page 156.
7. American Academy of Family Physicians. (2009). *AAFP Reference Manual – Selected Policies on Health Issues.* Kansas City, MO. from www.aafp.org/online/en/home/policy/policies/i/integratedpracticearrangements.html.
8. The Pew Health Professions Commission. (1998). *Charting a Course for the Twenty-First Century – Physician Assistants and Managed Care.* San Francisco, CA. UCSF Center for the Health Professions.
9. Dhuper, S., & Choksi, S. (2009). Replacing an academic internal medicine residency program with a physician assistant-hospitalist model: a comparative analysis study. *American Journal of Medical Quality,* 24(2), 132-139.
10. Wilson, I.B., Landon, B.E., Hirschhorn, L.R., McInnes, K., Ding, L., Marsden, P.V., et al. (2005). Quality of HIV care provided by nurse practitioners, physician assistants, and physicians. *Annals of Internal Medicine,* 143(10), 729-736.
11. Miller, W., Riehl, E., Napier, M., Barber, K., & Dabideen, H. (1998). Use of physician assistants as surgery/trauma house staff at an American College of Surgeons-verified level II trauma center. *The Journal of Trauma: Injury, Infection, and Critical Care,* 44(2), 372-376.
12. Rudy, E.B., Davidson, L.J., Daly, B., Clochesy, J.M., Sereika, S., & Baldisseri, M. (1998). Care activities and outcomes of patients cared for by acute care nurse practitioners, physician assistants, and resident physicians: a comparison. *American Journal of Critical Care,* 7(4), 267-281.
13. Oswanski, M.F., Sharma, O.P., & Raj, S.S. (2004). Comparative review of use of physician assistants in a level I trauma center. *The American Surgeon*, 70(3), 272-279.
14. Roblin, D.W., Becker, E.R., Adams, K., Howard, D.H., & Roberts, M.H. (2004). Patient satisfaction with primary care: does type of practitioner matter? *Medical Care*, 42(1), 579-589.
15. Hooker, R.S., Cipher, D.J., & Sekscenski, E. (2005). Patient satisfaction with physician assistant, nurse practitioner, and physician care: a national survey of Medicare beneficiaries. *Journal of Clinical Outcomes Management,* 12(2), 88-92.
16. American Medical Association, Center for Health Policy Research. (1995). *Socioeconomic Characteristics of Medical Practice.* Chicago, IL; Gonzalez, ML, ed.
17. Iliff, D. (1998). Solo practice: the way of the future. [Electronic Version] *Family Practice Management,* 5(16).

* [This figure represents typical but not universal prerequisite study for entry to PA education. Each PA educational program sets its own prerequisites for application.]

THIRD-PARTY REIMBURSEMENT FOR PHYSICIAN ASSISTANTS

From the AAPA.
(http://www.aapa.org/uploadedFiles/content/Common/Files/RI_3rdParty_v4%20-%20052711%20UPDATED.pdf)

Medicare Coverage for Physician Assistants

The first Medicare coverage of physician services provided by physician assistants was authorized by the Rural Health Clinic Services Act in 1977. In the following two decades, Congress incrementally expanded Medicare Part B payment for services provided by PAs, authorizing coverage in hospitals, nursing facilities, rural Health Professional Shortage Areas, and for first assisting at surgery. In 1997, the Balanced Budget Act extended coverage to all practice settings at one uniform rate.

As of January 1, 1998, Medicare pays the PA's employer for medical and surgical services provided by the PA in all settings at 85 percent of the physician's fee schedule. This includes hospitals (inpatient, outpatient, operating room and emergency departments), nursing facilities, offices, clinics, the patient's home and first assisting at surgery. Submit the bill at the full physician rate. Use of the PA's National Provider Identification (NPI) number will alert the carrier to reduce the payment to 85 percent of the physician's fee schedule. Assignment is mandatory and state law determines supervision and scope of practice except for 'incident to' billing. Hospitals that employ PAs (and physicians) must bill for their clinical services under Medicare Part B. PA salaries may not be included in the hospital's cost reports unless the PA is providing administrative (non-clinical) duties.

Outpatient services provided in offices and clinics may still be billed under Medicare's 'incident-to' provisions, if Medicare's more restrictive billing guidelines are met. This allows payment at 100 percent of the fee schedule if: (1) the physician is physically on site when the PA provides care, (2) the physician personally treats and establishes the diagnosis for Medicare patients on their first visit for a particular medical problem (PAs may provide the subsequent care) and (3) established Medicare patients with new medical problems are personally treated and diagnosed by the physician (PAs may provide the subsequent care). The physician must remain a part of the patient's care at a frequency that reflects his/her ongoing involvement.

PAs billing under their own names and NPI numbers (using the 85 percent benefit) may be W-2, leased employees, or independent contractors. The employer would still bill Medicare for the services provided by the PA. PAs who treat Medicare patients should be enrolled in the Medicare program. PAs enroll with Medicare by first obtaining an NPI number (https://nppes.cms.hhs.gov) and then submitting an 855i application to their local Medicare carrier or Medicare administrative contractor.

All health care professionals who transmit or receive health care information electronically must have an NPI number. The NPI number is the identification number used by public and private third-party payers. It replaces Medicare's PIN, UPIN, and the various provider numbers issued by all other payers.

CMS allows PAs to have up to a 99 percent ownership interest in a state-approved corporate entity (*e.g.*, professional medical corporation) that bills the Medicare program, if that corporation qualifies as a provider of Medicare services. The remaining one percent may be owned by anyone chosen by the PA, as allowed by state law.

Medicaid Coverage

Currently, all 50 states and the District of Columbia cover medical services provided by PAs under their Medicaid fee-for-service or Medicaid managed care programs. The rate of reimbursement is either the same as or slightly lower than that paid to physicians.

Private Insurance

Nearly all private payers cover medical and surgical services provided by PAs. Some payers will separately credential and issue provider numbers to PAs. Others require that services delivered by PAs be billed under the name and NPI number of the PA's supervising physician. It is important to note that there is no direct relationship between PAs being credentialed or enrolled, and payment for medically necessary services provided by PAs. Payment for services provided by PAs is made according to the policy of the payer.

Private health insurance companies do not necessarily follow Medicare's coverage policy rules. As private entities they are able to establish their own rules and procedures. The potential variation in policy among the various payers makes it imperative that each payer be contacted to determine its specific payment and coverage policies for PAs. Even within the same insurance company, PA coverage policies can change slightly, based on the particular plan that an individual or group has selected, the specific type of service being provided, and the part of the country in which the service is delivered.

When a private payer asks for the service to be billed under the name of the supervising physician, it does not necessarily mean that the payer is suggesting that the rules of Medicare's 'incident to' billing be utilized. Often payers will defer to supervision requirements as required by state law, even when the PA's services are billed under the name and NPI number of the supervising physician.

TRICARE/CHAMPUS

TRICARE, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), covers all medically necessary services provided by a physician assistant. The PA must be supervised in accordance with state law. The supervising physician must be an authorized TRICARE provider. The employer bills for the services provided by the PA.

Reimbursement for services provided by PAs under TRICARE Standard, the fee-for-service program, except assisting at surgery, is 85 percent of the allowable fee for comparable services rendered by a physician in a similar location. Reimbursement for assisting at surgery is 65 percent of the physician's allowable fee for comparable services.

PAs are eligible providers of care under TRICARE's two managed care programs, TRICARE Prime and Extra. TRICARE Prime is similar to an HMO. TRICARE Extra is run like a preferred provider organization in which practitioners agree to accept a predetermined discounted fee for their services.

Medicare Policy Chart for Physician Assistants

Setting	Supervision Requirement	Reimbursement Rate	Services
Office/clinic when physician is not on site	State law	85% of physician fee schedule	All services PA is legally authorized to provide that would have been covered if provided personally by a physician
Office/clinic when physician is on site	Physician must be in the suite of offices	100% of physician fee schedule[1]	Any service provided to established patients of the practice and related to ongoing conditions for which care plan established by practice physician
Home visit/ house call	State law	85% of physician fee schedule	All services PA is legally authorized to provide that would have been covered if provided personally by a physician
Skilled nursing facility & nursing facility	State law	85% of physician fee schedule	Same as above
Hospital: non-shared visit	State law	85% of physician fee schedule	Same as above
Hospital, shared visit service	State law	100% of physician fee schedule	Any non-consultation E/M service: no procedures, no critical care
First assisting at surgery in all settings	State law	85% of physician fee schedule[2]	All services PA is legally authorized to provide that would have been covered if provided personally by a physician
Federally Certified Rural Health Clinics	State law	Cost-based reimbursement	Same as above
HMO	State law	Reimbursement on a capitation basis	All services contracted for as part of an HMO contract

[1] Using carrier guidelines for 'incident to' services.
[2] i.e., 85% x 16% = 13.6% of surgeon's fee.

PHYSICIAN ASSISTANTS IN HOSPITAL PRACTICE: CREDENTIALING AND PRIVILEGING

From the AAPA.
(http://www.aapa.org/uploadedFiles/content/Common/Files/HP_PAs_HospitalPractice_v4%20-%20052711%20UPDATED.pdf)

Physician assistants who practice in hospitals are diverse and highly skilled professionals who are found in virtually every department, working with physicians of every medical and surgical specialty. They may be employed by the hospital (or system) or by medical practices or hospital medical groups. While PAs can be found working almost anywhere in a hospital, they most often practice on inpatient services, in emergency departments, operating rooms, outpatient units, and critical care/intensive care units.

The level of physician supervision required is defined in state law and in hospital policy. All state laws allow the flexibility of off-site supervision by physicians as long as they are available to the PA via telecommunication. In developing their supervision policies, most hospitals choose to follow state law; however, they do have the option of being more stringent (but not less) than the requirements of law. (Federally employed PAs are governed by federal agency guidelines rather than state law.)

Privileging Physician Assistants

To provide patient care in the hospital, PAs and their supervising physicians must seek delineation of their clinical privileges. The process for granting clinical privileges to PAs should be outlined in the medical staff bylaws. The bylaws should include a definition of physician assistant, generally conforming to the definition used in state law and to the general definition of a PA used by the American Academy of Physician Assistants. An example might be as follows.

> A physician assistant (PA) is an individual who is a graduate of a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant or by one of its predecessor agencies (the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs); and/or who is certified by the National Commission on Certification of Physician Assistants; and who is licensed, registered, or certified to practice medicine with physician supervision.

The Joint Commission medical staff standards require hospitals to credential and privilege PAs through the medical staff or by another 'equivalent process.' Bylaws should stipulate that all clinical privileges granted to PAs be consistent with all applicable state laws and regulations and that a PA may provide medical services that are within the scope of practice of the supervising physician.

Credentialing Physician Assistants

Hospitals that wish to grant privileges to a PA should verify that the individual is properly licensed, certified or registered by the state and has adequate liability insurance. Credentials verification should include queries of the National Practitioner Data Bank (NPDB) for

malpractice information and the Federation of State Medical Boards (FSMB) for records of disciplinary actions taken against the PA. The American Medical Association's (AMA) Physician Profile Service also offers PA credentials verification. For a nominal fee, credentialing professionals can confirm a PA's education program attendance and graduation date, national certification number and status, current and historical state licensure information, and AAPA membership status. The Joint Commission has deemed that the education information and national certification data are equivalent to primary source information.

To credential PAs, many hospitals adapt their physician forms and criteria to create a parallel process for PAs. The criteria usually are defined in the medical staff bylaws or in an associated policy and procedures manual. On demonstration of satisfactory training and experience, and after approval by the hospital board or designated individual, a PA may be granted privileges with supervision of a physician(s) who has appropriate privileges.

Reappointment/Reprivileging

As with physicians, hospital bylaws should specify a time period for the renewal and revision of physician assistant privileges and reappointment to the medical staff. The medical staff should evaluate information provided by physician supervisors and physician assistant peers on the PA's professional performance, including technical and clinical skills. They also should evaluate information on performance improvement, including continuing medical education and other courses completed. The PA's scope of practice should be updated as changes in clinical privileges are made. Queries to the NPDB and FSMB should be made any time privileges are renewed, revised or expanded.

Medical Staff Membership

Medical staff bylaws identify the categories of providers eligible for membership. AAPA believes that PAs should be members of the medical staff because they provide medical care. While their authority to provide care is delegated by a supervising physician, PAs exercise a high level of decision-making and autonomy in day-to-day practice. The AAPA recommends that medical staffs credential and privilege all PAs and include them as members, with all of the committee involvement, quality measures and peer review that are part of medical staff oversight. Both Joint Commission standards and Medicare and Medicaid Conditions of Participation for Hospitals allow PA membership on medical staffs. State law should be consulted; some state laws define which professionals can be medical staff members.

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

The issue of professional liability is of great concern to every physician and institution. The reasons for malpractice suits are beyond the scope of this outline. In relation to physician assistants, you may wonder about malpractice issues or whether the PA's presence in the hospital might increase the institution's liability potential. This page provides introductory information concerning PAs and the malpractice issue.

1) While the MEDEX student is participating in his or her clinical training at the University of Washington, the UW provides professional liability insurance under its self-insurance plan. In other words, the university will pay for claims with their actuarially determined self-insurance reserves. After the student has graduated from the program and registered with the Board of Medical Examiners, insurance must be obtained by the physician for the PA.

2) As defined in enabling legislation, most PAs perform under the Medical Practice Act of their respective states, and those acts are ultimately the responsibility of the physician or preceptor supervising the PA. Therefore, physicians have clear legal accountability and must protect themselves and the PA with appropriate liability insurance. It has long been customary for a physician to have a rider attached to his or her policy including coverage for the PA.

3) The American Academy of Physician Assistants (AAPA) advises that PAs should have individual coverage in addition to the rider policy in order to address potential gaps in coverage. PA liability insurance should be considered to be a part of the employer's usual administrative expenses.

4) The use of a PA enables the physician to spend more time with the seriously ill and the PA more time with the other patients, which may result in improved patient-physician rapport and communication. Studies have shown that having a PA in the practice or institution does not increase—and may decrease—the risk of malpractice litigation.

Additional discussion of this topic may be found on the AAPA web site.
http://www.aapa.org/your_pa_career/malpractice_insurance.aspx

Physician Assistant Malpractice Coverage

There are various providers of PA malpractice insurance with varying coverage and rates. Ask your current malpractice carrier about PA liability insurance. PA malpractice insurance is also available as a benefit to members of the AAPA.

AAPA Insurance Services
2318 Mill Road, Suite 1300
Alexandria, VA 22314
Phone: (703) 836-2272