Family Medicine Clerkship

MSPA 627 – 4.5 Credits

Day(s): Determined by Clinical site/preceptor	**Time(s):** Determined by Clinical site/preceptor	**Classroom:** Refer to Typhon schedule
Instructor: Michelle Lea, PA-C and Christine Rowland, PA-C	**Office Hours:** M, Tu, Th, F 9am-5pm	**Office Location:** END 113A
Phone: 203-576-4180		**Email:** ubpaclinicals@bridgeport.edu

The University of Bridgeport and its faculty are committed to enhancing diversity, equity, inclusion, and belonging in all facets of community life and to promoting an optimal environment for learning which encourages engagement, authenticity, and respect. Diversity in the classroom—in race, gender, sexual orientation, religion, language, ability, veteran status, place of origin, etc.— is an asset to our learning experience. Students play a vital role in the ongoing conversation about how to make the campus a place for community learning.

Prerequisite/Co-requisites: Completion of PAI didactic phase with a GPA of 3.0 or greater.

Course Description

is a 5-week clinical clerkship course. During this course, second year PA students develop skills necessary to function as a PA in the family medicine setting. Students will apply the medical knowledge and technical skills developed during didactic phase of their education. Students will actively engage in the assessment, analysis, evidence-based approaches, and management of conditions in a culturally sensitive and patient-centered manner. Student will encounter patients typically seen in the family medicine setting. Students will work with the clinical education team and under the supervision of their preceptor(s) to provide care. Students will follow their preceptor's schedule when on clinical site.

Required Learning Materials and Text(s)

1. Kayingo, G, Opacic, D, Carcella Allias, M. *The Physician Assistant Student's Guide to the Clinical Year. Family Medicine*. Springer Publishing Company; 2020.
   ISBN: 9780826195227

2. Gonzales PA, McDonald MA. *The PA Rotation Exam Review*. Lippincott Williams & Wilkins; 2024.
   ISBN: 9781975193355

Students: Your required course materials have been provided for you. Please contact the UB Bookstore to receive your textbooks for the course.

Recommended Text(s)

South-Paul JE, Matheny SC, Lewis EL. *CURRENT Diagnosis & Treatment: Family Medicine*, *5e.* New York Mcgraw-Hill
ISBN: 978-1-2601-3489-6

Course Goal

The purpose of the Internal Medicine clerkship is to provide the PA student with a 5-week clinical experience in the diagnosis and treatment of acute and chronic conditions which are typical of the internal medicine population. This clerkship requires students to develop their ability to manage chronic illnesses effectively while being able to recognize the development of acute illness. Student will need to demonstrate their ability to critically think and formulate treatment plans under the supervision of experienced internal medicine practitioners.

Course Format

During this 5-week rotation students will gain hands on clinical experience while working with an experienced family medicine clinician. Working with preceptors, students will perform history and physical examinations, present oral and written cases, identify differential diagnoses, and develop assessment and management plans. Students will also learn to perform and evaluate diagnostic and therapeutic procedures under the supervision of the preceptor. Additional and supplementary modular components include assignments, resources, and simulated clinical learning. Supplementary simulated clinical learning and self-paced modules are not substituted for in-person clinical experiences.

Student Learning Outcomes

By the end of this course, students should be able to:

	Student Learning Outcome
SLO1	Elicit an accurate medical history for a) children, b) adolescents, c) adults.
SLO2	Perform an appropriate physical examination for a) children, b) adolescents, and c) adults.
SLO3	Demonstrate effective communication of patient encounters a) orally and in b) written form.
SLO4	Diagnose common conditions in a) children, b) adolescents and c) adults seen during acute patient encounters.
SLO5	Diagnose common conditions in a) children, b) adolescents and c) adults seen during chronic patient encounters.

SLO6	Diagnose common conditions in a) children, b) adolescents and c) adults seen during preventive patient encounters.
SLO7	Utilize clinical data to formulate a differential diagnosis.
SLO8	Demonstrate the application of diagnostic studies commonly used in the family medicine discipline.
SLO9	Formulate an appropriate patient management care plan based on clinical data collected.
SLO10	Provide patient education with consideration for health literacy and belief systems.
SLO11	Demonstrate clinical reasoning and problem-solving abilities in the evaluation and care of patients.
SLO12	Demonstrate patient-centered care through compassion and sensitivity.
SLO13	Demonstrate professionalism by adhering to the professional conduct standards of the PA profession.
SLO14	Describe appropriate preventive screening recommendations based on patient demographics in the family medicine discipline.
SLO15	Accurately interpret urinalysis studies.
SLO16	Demonstrates proper technique when performing injections.

Learning Activities, Course Expectations, and Grading Policy

The final course grade will be calculated using the following (all components graded to the nearest hundredth):

Assessment	Percentage of Final Grade	Brief Description of Assessment
End of Rotation Exam	55%	A comprehensive examination based on course objectives and the NCCPA and PAEA blueprint. End of Rotation examination grade is calculated based on the student's Z-score. **Z-score less than -1 will result in a grade below 73 and failure of the exam**. Should a student fail an end-of-rotation examination, a meeting with the Coordinator of Academic Affairs will be arranged and a remediation plan will be designed. Upon completion of the remediation, a retest will be given. If a student passes the End of Rotation reassessment exam (i.e., earning 73% or higher), the student will receive a 73% for the End of Rotation Exam component regardless of grade earned on the reassessment exam. Failure of reassessment exam will result in failure of the rotation. Students are permitted **one EOR exam reassessment** for the clinical year.
Mid-Rotation Evaluation	Reduction Only	Mid-way through the clinical clerkship, the student is required to sit down with the preceptor to discuss the

		student's performance and provided constructive feedback. This session is documented on the Mid-Rotation Evaluation Form. The blank form can be found in Canvas and should be uploaded to Assignments in Canvas once complete. This is a non-graded exercise but provides the student and program invaluable feedback on the student's progress in meeting program objectives and learning outcomes. Professionalism points will be deducted if not uploaded to Canvas by Wednesday at 11:59pm est of the third week of the clerkship.
Preceptor Evaluation	35%	Each student is evaluated by the preceptor at the end of each rotation. Preceptor evaluations are submitted via the Typhon logging system utilizing a four-point Likert scale. Typhon calculates the final percentage grade by averaging the mean of each section. The final percentage grade in Typhon will be utilized to calculate your final course grade. Any component of the preceptor evaluation which result in an "Approaches Expectations" or "Unsatisfactory", will require remediation.
Clinical Modules & Documentation Assignment	10%	Rotation specific clinical modules are located in Canvas. The modules contain extra resources and assignments related to the clinical clerkship experience that must be completed and uploaded to Canvas by 11:59pm est on Call-back Day (unless otherwise noted in Canvas). See Canvas and rubrics for details. There is no credit for late assignments.
Professionalism	Reduction only	Professionalism is an expectation and non-compliance with any of the terms below will result in a 1-point deduction from your final grade. For example, if your total weighted grade (55%+ 35%+10%=100%) is an 80%, a professionalism deduction would result in a 79%. One non-compliant event equals 1-point deduction per event, per rotation and can be up to 5-points per rotation. If professionalism points are to be deducted, you will be notified by faculty via email of the infraction. Warnings will not be given. The deduction will not be applied until the total grades are weighted and calculated. Examples of infractions: i. Attendance and participation ii. Adherence to procedures and policies iii. Uploading clinical schedule to Typhon iv. Submission of complete case logs in Typhon

		v. Submission of clerkship paperwork as requested by the Clinical Coordinator

Students must meet all the following standards to pass the clerkship course:

1. 73% or greater on the Preceptor Evaluation.
2. 73% or greater on the EOR Exam (see policy regarding reassessment above).
3. 73% or greater on the final course grade.

Failure of a Clinical Clerkship Course, will require the student to repeat the clerkship, resulting in a delay of graduation. Failure to meet any of the above requirements will result in an "F" for the course.

Final grades are assigned by the instructor based on the **University of Bridgeport Institutional Grading Scale** published in the UBPAI Student Handbook.

Final Course Grading Scale

Grade	Quality Points
A (93-100)	4.0
A- (90-92.99)	3.7
B+ (87-89.99)	3.3
B (83-86.99)	3.0
B- (80-82.99)	2.7
C+ (77-79.99)	2.3
C (73-76.99)	2.0
C- (70-72.99)	1.7
D+ (67-69.99)	1.3
D (63-66.99)	1.0
D- (60-62.99)	0.7
F (below 60)	0.0

There is no rounding up of grades.
As per the UB PAI Student handbook, the required passing grade for all PA coursework is a "C" or better.

Course Outline

Dates	Topic(s) Covered	Assignments/ Reading to be completed before class	Assessment Schedule
Block 1: Mar 18, 2024 – April 18, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Apr 19, 2024

Dates	Topic(s) Covered	Assignments/ Reading to be completed before class	Assessment Schedule
Block 2: May 6, 2024 – Jun 10, 2024	• Instructional Objectives 1-16	• Required text	• Friday Jun 7, 2024
Block 3: Jun 10, 2024 – Jul 11, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Jul 12, 2024
Block 4: Jul 15, 2024 – Aug 15, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Aug 16, 2024
Block 5: Sept 9, 2024 – Oct 10, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Oct 11, 2024
Block 6: Oct 14, 2024 – Nov 14, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Nov 15, 2024
Block 7: Nov 18, 2024 – Dec 19, 2024	• Instructional Objectives 1-16	• Required text	• Friday, Dec 20, 2024
Block 8: Jan 13, 2025 – Feb 13, 2025	• Instructional Objectives 1-16	• Required text	• Friday, Feb 14, 2025
Block 9: Feb 17, 2025– Mar 20, 2025	• Instructional Objectives 1-16	• Required text	• Friday, Mar 21, 2025

This syllabus is subject to change at the discretion of the instructor.

Instructional Objectives

SLO	Instructional Objective
1.	• **1.1**: Establish rapport with a patient and/or their caregiver. • **1.2**: Determine the chief complaint and list of major problems. • **1.3**: Establish the purpose of a visit. • **1.4**: Select appropriate level of history based on the purpose of the visit. • **1.5**: Select the questions to obtain a thorough history of present illness. • **1.6:** Obtain past medical history, family history, and social history, applicable to the purpose of the visit. • **1.7**: Elicit an appropriate review of systems.
2.	• **2.1**: Identify possible physical exam findings related to the symptoms elicited during collection of medical history. • **2.2**: Select the areas to examine pertinent to the presenting complaints, age, gender, and patient's ability to participate.

	• **2.3:** Apply appropriate techniques to examine the patient with attention to patient's modesty and privacy needs.
3.	• **3.1:** Confidently and concisely report applicable demographic information, chief complaint, HPI, past medical history, and pertinent ROS. • **3.2**: Identify and report pertinent physical exam findings including presence and absence of clinically significant signs based on presenting features. • **3.3:** Select the type of documentation appropriate for the purpose of the visit, such as SOAP note, H&P note, etc. • **3.4**: Document chief complaint and all pertinent components of patient's history using appropriate medical terminology. • **3.5:** Document all pertinent normal and abnormal physical examination findings using appropriate medical terminology. • **3.6** Identify common ICD-10 and CPT codes used in patient encounter documentation.
4.	• **4.1**: Identify pathophysiologic process of development of acute conditions commonly seen in the family medicine practice. • **4.2**: Identify risk factors and demographics mostly susceptible to the development acute conditions typically seen in the family medicine setting. • **4.3**: Recognize the clinical presentation of acute conditions typically seen in family medicine setting. • **4.4**: Apply knowledge of pathophysiology to diagnosis and management of acute conditions typically seen in family medicine setting.
5.	• **5.1**: Identify pathophysiologic process of development of chronic conditions commonly seen in the family medicine setting. • **5.2**: Identify risk factors and demographics mostly susceptible to the development of chronic conditions typically seen in the family medicine setting. • **5.3**: Recognize the clinical presentation of chronic conditions typically seen in family medicine setting. • **5.4**: Apply knowledge of pathophysiology to diagnosis and management of chronic conditions typically seen in family medicine setting.
6.	• **6.1**: Identify age-appropriate preventive screening recommendations for routine preventive visits. • **6.2**: Identify risk factors and demographics mostly susceptible to the development of preventive conditions typically seen in the family medicine setting. • **6.3**: Identify age-appropriate interventions such as vaccines for during routine preventive visits.
7.	• **7.1**: Correlate medical history findings with the reported symptoms. • **7.2:** Correlate normal and abnormal findings of physical examination with the reported symptoms. • **7.3:** Integrate the information collected during medical history and physical examination to formulate the initial list of differential diagnoses. • **7.4:** Discriminate between the conditions on the differential diagnosis list by explaining similarities and key differences.

8.	• **8.1:** Identify indications for laboratory tests and imaging studies, and other diagnostic evaluations commonly used in family medicine setting.
	• **8.2:** Identify diagnostic studies recognized as screening, "gold standard" diagnostic, and first tests to order.
	• **8.3**: Interpret in the context of presenting symptoms the following commonly used laboratory tests:
	  • Complete blood count
	  • Basic and Comprehensive metabolic panel
	  • Thyroid function tests
	  • Lipid profile

	• Hemoglobin A1c • Urinalysis • Point of care testing such as rapid Strep test, rapid Covid test, pregnancy test, rapid flu test, etc. • **8.4**: Interpret in the context of the presenting symptoms the following diagnostic studies: • EKG • Plain film chest X-ray
9.	• **9.1:** Discuss all treatment options with patients with attention and sensitivity to belief systems, access to care and health literacy. • **9.2:** Identify the specific concerns and needs of each patient and assist with referrals to services and support as indicated. • **9.3:** Involve patients and caregivers in the treatment planning process with sensitivity to cultural beliefs, patient preferences, cost effectiveness, and patient's ability to access care. • **9.4:** Identify any barriers to plan adherence and identify resources to improve access to care.
10.	• **10.1**: Identify patients' level of health education and determine the best manner of communicating health information pertinent to the case. • **10.2**: Provide the patients with information about their diagnosis and the course of therapeutic intervention. • **10.3**: Demonstrate respect to patients' system of beliefs and align your communication to the patient's preferred style. • **10.4:** Educate the patients on non-medical intervention and health prevention measures aligned with their readiness to comply and their belief system. • **10.5**: Identify the need and utilize the interpreters when necessary. • **10.6:** Utilize patient education techniques such as the teach back method to ensure understanding.
11.	• **11.1**: Identify the investigations and studies necessary to assess and narrow down the differential diagnoses list. • **11.2**: Integrate laboratory and diagnostic studies results with history and physical examination data to establish the most likely diagnosis. • **11.3**: Analyze available care options for the conditions commonly seen in family medicine setting and determine their applicability in each individual case.
12.	• **12.1:** Assess patient's readiness to adhere to suggested treatment options and provide respectful support for patient's decision making. • **12.2:** Engage in active listening techniques during communication with patients and their families in the family medicine setting. • **12.3:** Identify need for enhanced communication options such as involvement of interpreters. • **12.4:** Incorporate patient's health literacy level and cultural beliefs when providing care.
13.	• **13.1:** Demonstrate professional demeanor in all interactions in a family medicine setting: with staff, medical providers, patients, and their family members. • **13.2:** Adhere to ethical, legal, regulatory, and behavioral norms at all times. • **13.3**: Demonstrate punctuality, consistency, and reliability in relating to the family practice team and patients.
14.	• **14.1:** Identify age-appropriate screening based on the USPSTF recommendations based on age. • **14.2:** Identify patients at higher risk for conditions such as colon and breast cancers and incorporate appropriate screening recommendation schedules. • **14.3:** List risk factors for common preventable diseases.
15.	• **15.1:** Accurately interpret the presence of the components of the urinalysis including WBC, nitrites, blood, pH, ketones, and glucose.

	• **15.2:** Identify the possible causes of abnormal findings on the urinalysis.
16.	• **16.1:** Utilize proper aseptic technique when preparing the injection site. • **16.2:** Properly perform IM, subcutaneous, and intradermal injections. • **16.3:** Demonstrate safe and proper disposal of needles.

Class Policies

- **Attendance policy**: Please refer to the student handbook and clinical handbook for the program policy on attendance.
- **Late assignments policy:** Late work is not accepted, and students will receive a zero for the assignment.
- **Course failure policy**: Please refer to the student handbook and clinical handbook for the program policy on course failure.
- **Professionalism**: Please refer to the student handbook and clinical handbook for the program policy on Disciplinary Action for Professional and Behavioral Issues and professionalism.
- **E-mail policy**: Please refer to the student handbook for the program policy on e-mail.
- **Exam and Remediation policy**: Please refer to the student handbook and clinical handbook.
- **Academic Integrity**: Please refer to the student handbook.
- **Student Accessibility Accommodations**: Please refer to the student handbook.

UNIVERSITY OF BRIDGEPORT POLICES AND STUDENT SERVICES
This course adheres to all policies outlined in the catalog and in the Key to UB.

General academic policies of the University of Bridgeport can be found on the University website and in the University catalog at https://catalog.bridgeport.edu/.

Student services information may be found on the University of Bridgeport website at https://www.bridgeport.edu/heckman-center/academic-success/ and in the Key to UB at https://www.bridgeport.edu/key-to-ub/.

ACADEMIC HONESTY STANDARDS

The University of Bridgeport is committed to fostering an environment of academic integrity, mutual respect and individual responsibility. We are a community that values the voice of students in their pursuit of academic excellence and personal growth. By choosing to be a member of this community, each student demonstrates respect for the core values of trust, honesty and ethical behavior and commits to upholding these standards.

Please refer to the *Student Handbook (Chapter 2 of "Key to UB" (*https://www.bridgeport.edu/key-to-ub/chapter-2-academic-standards#integrity) to become familiar with the academic honesty standards expected of all students, including a definition of plagiarism. Claiming ignorance will not be considered a valid defense. All types of academic dishonesty (including but not limited to plagiarism, the use of illicit aid or internet resources during the examinations, giving or receiving aid on any examination, copying another

student's work, utilizing unauthorized web-based services to complete assignments, providing a false excuse for missing a test) are inexcusable and will result in a report to the Provost's Office and appropriate disciplinary action.

The number of violations accrues to each student during total time as a University of Bridgeport student at any level.

STUDENT ACCESSIBILITY SERVICES

https://www.bridgeport.edu/student-accessibility/

In compliance with Section 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Connecticut State Laws, Student Accessibility Services (SAS) at UB provides reasonable accommodations to reduce the impact of disabilities on academic functioning or other life activities in the University setting.

Student Accessibility Services (SAS) offers a private and confidential atmosphere for students to talk about their disabilities and accommodations requests. In order to begin the process of requesting accommodations, students can contact Student Accessibility Services (SAS) at (203) 576-4104 or email **accessibilityservices@bridgeport.edu**.

A list of student resources can be found on the UB website, under Student Affairs:
https://www.bridgeport.edu/student-affairs/