Clinical Rotation Learning Outcomes

BEHAVIORAL HEALTH

GENERAL GUIDELINES

Under the guidance of experienced providers, clinical rotations provide a PA student with opportunities to actively participate in direct patient care in the role of a developing practitioner. When appropriate, students are expected to demonstrate clinical skills and take part in relevant procedures with minimal reliance on observational experiences.

Orientation

Preceptors are encouraged to provide a brief orientation prior to or within the first few days of the rotation. This should include expectations, clinic workflow and schedule, documentation requirements, and opportunities for student involvement. Students should be invited to share a few personal goals and/or questions at the start of the experience to clarify expectations and promote a productive learning environment.

Mid-Rotation Evaluation

Preceptors are encouraged to complete a brief mid-rotation evaluation to provide formative feedback on student performance. This evaluation does not impact the student's grade, but is intended to identify areas for strengths and growth. It also allows the program and preceptor to address issues proactively, provide coaching, and support the student's development. This will be sent to your email.

Preceptors are encouraged to provide timely, direct feedback throughout the rotation to allow students the opportunity to adjust, improve, and further develop their clinical skills.

End-of-Rotation Evaluation (Summative)

At the conclusion of the rotation, preceptors are asked to complete an end-of-rotation evaluation of the student. This evaluation helps the program assess student progress, attainment of learning outcomes and objectives, and readiness for increasing clinical responsibility.

Preceptors are encouraged to provide honest, constructive, and specific feedback to support student growth and professional development. While students receive a grade based on this evaluation, constructive and coachable feedback does not typically negatively impact a student's overall grade.

The following outcomes align with the end-of-rotation evaluation:

BEHAVIORAL HEALTH EXPERIENCES

Outcome 1: Comprehensive Evaluation
Perform comprehensive psychiatric evaluations, including mental status exams, diagnostic evaluations, and risk assessments, for patients with acute and chronic behavioral health concerns including anxiety, abnormal mood, panic attacks, insomnia, psychotic symptoms, suicidal ideation, and impulse-control and conduct concerns.

Outcome 2: Treatment Management
Formulate evidence-based management plans that address immediate safety concerns, guide appropriate diagnostic workup, and support long-term care, while evaluating and applying appropriate psychopharmacologic and other treatments. Student should have knowledge of commonly prescribed medications such as antipsychotics (1st and 2nd Gen), antidepressants (SSRIs, SNRIs, TCAs, NDRIs), anxiolytics and sedatives, stimulants and ADHD medications, and mood stabilizers.

Outcome 3: Emergent Behavioral Health Concerns
Recognize psychiatric emergencies and apply interprofessional, team-based approaches to initiate timely interventions, including referral, hospitalization, and collaboration with mental health and community resources.

PATIENT CARE

Outcome 1: History and Physical Exam
Obtain comprehensive and focused patient histories and perform comprehensive mental status exams within an appropriate amount of time.

Outcome 2: Patient Populations
Develop competency in delivering patient-centered care across the lifespan and for a broad spectrum of acute, chronic, and emergent behavioral health concerns, by evaluating, diagnosing, and managing patients, and providing preventative care.

Outcome 3: Upper-Level Involvement in Patient Care
Demonstrate upper-level involvement in **at least** 30% of patient encounters, defined as:

a. ***History/Exam and Significant A&P Attempt:*** The student performs a thorough and relevant history and physical examination and formulates an initial assessment and plan but requires guidance or correction by the preceptor for completeness, relevance, or accuracy.

b. ***History/Exam and Extensive/Accurate A&P:*** The student performs a thorough and relevant history and physical examination and independently formulates an accurate assessment and plan with little or no guidance from the preceptor.

MEDICAL KNOWLEDGE

Outcome 1: Diagnostic and Laboratory Studies
Demonstrate the appropriate use of laboratory and other diagnostic studies to rule out alternative diagnosis and to monitor treatment. Interpret and explain the results.

Outcome 2: Differential Diagnosis
Synthesize findings from patient history, examination, and diagnostic data to develop a differential diagnosis list.

Outcome 3: Most Likely Diagnosis and Diagnostic Determination
Apply clinical reasoning, medical knowledge, and diagnostic criteria to analyze a patient case to formulate and justify an evidence-based most likely diagnosis.

Outcome 4: Clinical Interventions
Determine appropriate evidence-based clinical interventions including treatment, pharmacotherapy, psychotherapy, patient education, follow-up, consultation, and referrals as appropriate.

COMMUNICATION

Outcome 1: Preventive Care and Health Maintenance
Effectively communicate patient-centered education on disease prevention and health maintenance, tailoring recommendations to the patient's age, risk factors, and health literacy, and incorporating current evidence-based guidelines to promote long-term wellness and treatment adherence.

Outcome 2: Interpersonal and Interprofessional Communication
Demonstrate effective interpersonal and interprofessional communication within the clinical setting by building rapport with patients, actively listening, navigating sensitive conversations, and collaborating respectfully with members of the healthcare team to support high-quality patient care.

Outcome 3: Oral Presentation

Deliver clear, organized, and concise oral presentations to the preceptor, of patient cases, including pertinent history, physical exam findings, assessment, and plan. Respond appropriately to questions and feedback.

Objective 4: Behavioral Health Care Case Documentation
Document an acute care case note based on a real patient encounter during the rotation, incorporating patient-specific risk factors, age-appropriate screening recommendations, health maintenance needs, and evidence-based behavioral health care guidelines. This assignment will be submitted to the PA program.