

ISSUE BRIEF

Payment of Clinical Sites and Preceptors in PA Education

INTRODUCTION

Effective clinical site and preceptor recruitment and retention are essential to the core functioning of every physician assistant (PA) program and to the long-term health of the PA profession. The numbers of available physical clinical spaces for training and preceptors willing to teach students have not been able to keep up with demand for education. The result is an insufficient clinical training capacity in the U.S. that affects PAs, physicians and nurse practitioners and has created unintended competition within and among health professions for these crucial components of their education. Various approaches to addressing these shortages are being implemented, including innovations in clinical education to maximize existing resources, as well as more controversial solutions that involve financial compensation. While paying clinical sites and preceptors is common at medical schools, it has not traditionally been a practice of the PA profession. This Issue Brief provides Physician Assistant Education Association (PAEA) members with a summary of current information on this topic so they may make informed decisions about how to manage this challenge in their own programs.

HISTORY AND CURRENT TRENDS

The practice of paying for supervised clinical training has a long history in medical education. Clinical departments were paid a lump sum to ensure that department heads would allow release time for clinical faculty to provide lectures and supervise

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medical students in clinical clerkships. This practice has evolved to include health professions programs paying directly for clinical teaching time in hospitals, clinics, and physician offices. In more recent years with the establishment of for-profit, offshore medical schools, there are reports of U.S. medical student displacement resulting in these schools paying sites at significantly higher rates than could be paid by domestic institutions for the same services.¹ This practice is opposed by The American Medical Association (AMA), which supports legislation or regulations that prohibit “extraordinary compensation for clinical clerkship sites by medical schools or other clinical programs that would result in displacement or otherwise limit the training opportunities” of U.S. medical students in clinical rotations.²

While the PA education system has historically relied on volunteer sites and preceptors, the trend of clinical payment has extended to certain programs, particularly in competitive markets. According to a recent survey conducted jointly by the Association of American Medical Colleges (AAMC) and PAEA, 65 percent of all program directors reported feeling moderate, high, or extremely high pressure to provide financial compensation to clinical sites. Over half of all program directors (50.7%) reported they are very concerned about the adequacy of the number of clinical training sites and preceptors for their students.³ Almost half of all program directors (46.7%) responded that payment requirements at clinical sites have a negative impact on their plans to increase enrollment. While there is increasing pressure for payment from hospital and clinical administrators, not all preceptors and in particular, PA preceptors, view lack of payment as an obstacle to clinical teaching. A 2011 survey entitled, “First National Survey of Physician Assistants and Preceptor Experiences” conducted by PAEA and National Commission on the Certification of Physician Assistants (NCCPA), determined that a “lack of financial compensation was reported as the least important factor in decisions to precept among all PAs”. This study also found that category one continuing medical education (CME) credit, student quality, and supervising physician’s support were far superior to financial compensation as motivators to precept.⁴

While there are no clear data on what is driving the increasing trend of clinical training payment, we have anecdotal evidence of the pressures facing the system. It appears that decreased reimbursement for patient care coupled with increased accountability for outcomes has sensitized health care administrators and providers to the potential financial burden of providing clinical education.

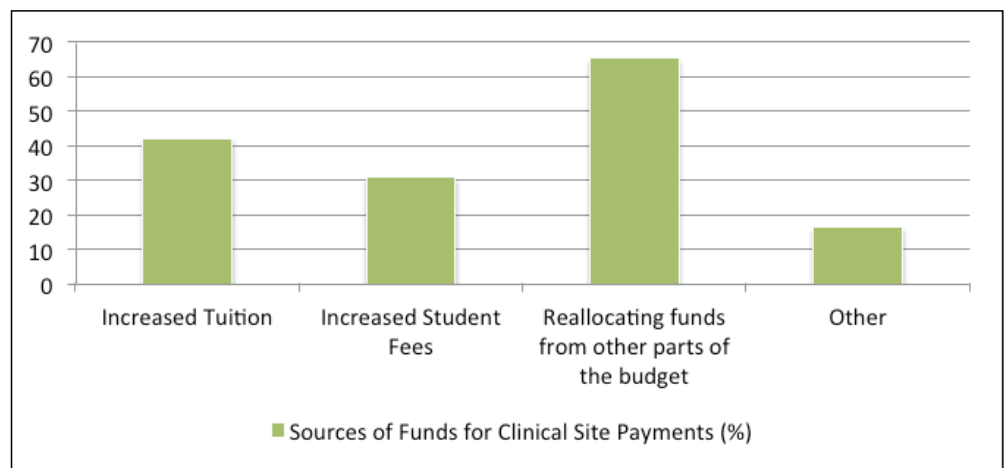
CONSIDERING THE COSTS

According to the most recent PAEA Annual Report, 21.1% of all programs indicated that they had allocated funds to pay preceptors.⁵ The AAMC PAEA clerkship study indicates that 21.7% of PA program survey respondents are paying for supervised clinical training, with a range of payments from \$100 to \$450 per student per week.³ Approximately, 16% of all respondents that did not pay clinical sites indicated that their programs had regulations or policies that prevented them from offering monetary compensation and another 20% indicated they did not know.

Payment for supervised clinical rotations typically increases the cost of education by \$12,000-15,000 per student. Schools have financed this expense through a variety of methods (see Table 1). When clinical payments are immediately passed on to students in form of increased tuition and/or fees, there may be unintended outcomes beyond the increased debt load. For example, increased cost of education may have a negative impact on the diversity of the applicant pool to PA education or effect graduate deployment to primary care.

Table 1.

Sources of Funds for Clinical Site Placements (%)



From: Clerkship Survey, 2013

Programs must thoroughly consider the implications of paying for supervised clinical education including increased debt load for repeat students.

DISCUSSION

Clinical preceptors and sites play a fundamental role in the education of future physician assistants. A changing health care environment that emphasizes increased accountability for patient outcomes achieved with potentially decreased resources will certainly impact clinical education and require programs to constantly reevaluate how they can continue to provide the “gold standard” in PA education. Each program must thoroughly consider the implications of paying for supervised clinical education. Regardless of the final decision, financial compensation should not replace relationship development including frequent personal contact, investing in training and development of preceptors, and ensuring well-prepared and enthusiastic trainees. Health care administrators and clinicians should be reminded that their participation is critical for the preparation of well-qualified future employees. A partnership model is likely to have better long-term positive results than a purely financial relationship.

PA programs that have decided to proceed with financial compensation for clinical sites and/or preceptors should clearly outline what the program will specifically be paying for and define expectations. In addition, they should anticipate and budget for future increased reimbursement rates and requests for payment from additional sites. In some cases, clinical payments can leverage exclusive affiliation agreements. However, bidding wars are a potential consequence of this practice. It also discourages opportunities for interprofessional team training.

PAEA’s mission is, in part, to “support programs in the recruitment, selection, development, and retention of well-qualified faculty.”⁶ Before initiating payment for clinical training, programs are encouraged to first consider offering nonfinancial incentives including volunteer faculty appointments, access to university resources, continuing medical education and awards and to seek counsel from PAEA about what other programs are doing successfully. The long-term impact of providing financial compensation to clinical sites is unknown, and its effect on programs that are unable to pay due to financial or policy constraints is also unclear. Although payment to clinical sites and/or preceptors is on the rise, how commonplace this arrangement will be in the future is unknown. Further study is needed to obtain empirical data related to the costs and benefits of paying for clinical education. Meanwhile, PAEA continues to advocate for its members by securing benefits for clinical preceptors such as continuing medical education credits, exploring payment reforms that recognize the cost of education, initiating dialogue with physician assistant employers about the value of participating in clinical education.

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