Phar 6230/6217

Ambulatory Pharmaceutical Care Clinic

Course Syllabus Spring 2019
2 Credits

This course adheres to the items listed in the College of Pharmacy Central Syllabus:
https://docs.google.com/a/umn.edu/document/d/1artQ5e1rbzxe8lEtWo7BE8k8snZAEgMMz_QcW8yJ-II/edit?pli=1

Meeting Times & Locations: TBD

	Day	Time	Duluth Room
Lecture	Mondays	Per schedule	Per schedule
Ambulatory Care Clinic Dates	Mondays	Per schedule	Per schedule

Course Website: canvas.umn.edu/courses/103025

Instructional Team

If you need assistance with the course, please contact the course director.

Technology Help, Duluth: 218-726-8847 itsshelp@d.umn.edu

Course Director
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Office Hours: By appointment

Teaching Assistants
See course website for roster and contact information

A Note from the Course Director

Dr. Bastianelli

My first exposure to pharmacy was as a teenager and I have been involved in the profession ever since. I strongly believe in the profession of pharmacy and all of the benefits we can bring to our patients and other health care professionals. Building relationships with patients has always been an important aspect of my professional philosophy and I am looking forward to not only teaching you, but getting to know each of you, and learning from you. In general, I am usually in my office (221 LSci) in the afternoon on Mondays, Tuesdays, and Thursdays. Please feel free to stop by my office anytime to discuss aspects of the course or any other topic of interest you may have. In order to ensure my availability, you may schedule an appointment with me through phone or e-mail. However, if I'm in my office with the door open, I'll be available to talk with you. I am also happy to respond to both e-mail and phone messages. Unless you are otherwise notified that I am out of town, I will respond to your messages within 24 hours (excluding weekends, in which case it may be 48 hours). If you should need to contact me to alert me of an illness or a family emergency, please leave me a voicemail as soon as possible.

Overview of the Course

Course Content

This course is designed to facilitate student learning while conducting pharmaceutical care assessments in patients with actual drug-related needs in a controlled clinic setting. This course will explore pharmaceutical care in community/ambulatory practice settings and provide emphasis and information on current topics affecting pharmacy practice. This course will also provide guidance and reinforcement of positive professional attitudes and commitment to pharmacy practice. This course may be repeated as Phar 6217: Advanced Ambulatory Care Clinic.

Course Format

Each student is expected to meet the following course requirements:

- Attend weekly two-hour interactive class sessions. Failure to make up an excused or un-excused absence will result in a one-half grade reduction (ex. A to A-) per occurrence.
- Provide pharmaceutical care to patients. Second or Third professional year students will primarily conduct the patient assessments. If paired, then Second professional year students will observe the assessment, conduct the patient assessment portion of the clinic visit (ie. blood pressure readings, etc), and serves as a care plan team member.
- First professional year students will primarily be responsible for documenting care and report follow-up interventions.
- All care plan team members may interact with the patient when needed to supplement the patient assessment process.
- All care plan team members are expected to participate in documentation, patient case presentations utilizing the Pharmaceutical Care – Case Presentation Format., and care plan development for each patient. Failure to meet expectations (as determined by course director and/or peer evaluation) will result in a one-half grade reduction (ex. A to A-) per occurrence.
- Conduct follow-up evaluations with the patient based on the agreement established between pharmacy students and the patient at the conclusion of the initial assessment. Follow-up evaluations may be conducted by the student with the patient either in-person or on the telephone and do not necessarily require the presence of a faculty member. Please note that more than one follow-up evaluation may be required to fulfill all of a patient's drug-related needs.
- All team members will be responsible for developing a Personalized Pharmaceutical Care Plan for the patient. The course director is required to co-sign the patient's Personalized Pharmaceutical Care Plan before distribution to the patient.
- All team members will be responsible to prepare document that would be appropriate communication with a physician. The course director is required to co-sign the document before distribution to the patient.
- Read selected book and submit a 3-4 page reflective paper due at final lecture.
- Complete all required readings.

- Submit a final course reflective paper due at the last lecture. The purpose of the final course paper is for the student to reflect upon care delivered to patients in the class, and how this experience is expected to help the student prepare for serving as a pharmaceutical care practitioner in the future.
- Complete an online course evaluation.

Prerequisites

The pharmaceutical care clinic course is open to all College of Pharmacy students (preference may be given to third year students).

- Pharm.D. III students enrolled in this course conduct and document patient assessments.
- Pharm.D. II students will be strongly encouraged to conduct assessments, rather than to serve as care plan team observers.
- Pharm.D. I students in this course are paired with an advanced-standing student to participate as an assessment observer and to serve as the care plan team member.
- Students must know the goal of the Pharm.D. program in Minnesota is to develop a competent generalist practitioner, and how a generalist practitioner is defined.
- Students should be committed to becoming a competent generalist practitioner who assumes responsibility, is willing to be held accountable for their patients' medication outcomes.
- Students must have successfully completed Becoming a Pharmacist

Requirements

Course Materials

Readings:

- Each student will be responsible for selecting and reading one Non-fiction book whose topic is related to health care concerns (subject to course director approval).
- Other readings as determined by instructor.

Course Website

This syllabus, as well as all of the details of the course (including schedules and documentation examples, etc.) can be found on the course website. Course announcements will also be posted on this site as necessary. It is expected that students check the website at least once a week.

Computer / Technology Requirements

The University of Minnesota computer requirements are listed as part of the CoP requirements.

Dress and Behavior Code

The Ambulatory Pharmaceutical Care Clinic is considered to be a professional setting during clinic appointments. Students are required to dress in a neat, clean, and professional manner. Professional demeanor is conveyed to your colleagues and patients in your behavior as well as in your appearance. Therefore, students must practice acceptable personal hygiene and grooming, as well as wearing a clean white lab coat with a College of Pharmacy-issued name tag. Lab coats from outside pharmacies are not acceptable unless the identification of the pharmacy is covered. Clothes that would be inappropriate in a patient care setting (i.e. t-shirts, shorts, short skirts (above the knees), open-toed shoes, flip-flops, jeans (regardless of color), abdomen exposing, low-cut, or off-the-shoulder shirts, and hats) are not acceptable.

If you come to clinic appointments wearing improper attire, you will automatically be given a one full grade reduction for the course and will be dismissed from the appointment.

Disruptive Behavior
Instructors have the authority and discretion to set rules that foster students learning. As a matter of academic freedom, these rules can be tailored to the subject matter and the instructor's teaching methods and leading objectives. For these reasons, the course instructor is the one who makes a determination about what constitutes disruptive behavior. Use of smartphones and tablets must be limited to electronic resources relevant to the current in-class activity.

Participation and Communication between Campuses via ITV

- Typically this course is NOT conducted via ITV. In the event we use ITV,
- When you are called upon in class to give a response or ask a question, please speak loud enough so that you may be heard by students on both campuses.
- Do not talk out of turn, wait to be recognized before speaking and do not try to dominate a discussion with your questions or comments- give others a fair opportunity to participate.
- Keep on the topic at hand. If you have questions off the current topic, address these outside of class at office hours or by email with the instructor.
- While we endeavor to make archives of all ITV lectures available to students in a timely way, we cannot guarantee that every course lecture will be recorded and posted successfully. ITV lecture archives are made available as a convenience and a study aid to students, but they are not considered a replacement for attending lectures. Students are responsible for the content discussed in face-to-face meetings regardless of whether lectures are successfully posted or not, and should plan accordingly

Goals & Objectives

Upon successful completion of this course the student will be able to:

- Successfully engage a patient in a therapeutic relationship through performing a comprehensive patient assessment, including: interviewing a patient, performing appropriate physical assessment techniques, completing a health history, and completing a drug utilization review.
- Assess all of a patient's drug-related needs for the purpose of identifying drug therapy problems and establishing drug therapy treatment goals.
- Develop individualized and clinically appropriate care plans to resolve and prevent drug therapy problems; as well as, ensuring that patients are fully educated and understanding their drug therapy in order to better achieve drug therapy treatment goals.
- Present patient cases in class using the Pharmaceutical Care Case Presentation format.
- Document and Communicate effectively with patients and other health care providers.
- Conduct a follow-up evaluation with a patient to determine actual patient understanding and/or outcomes.
- Recognize legislative and reimbursement issues.
- Exhibit professional behavior.
- Accept the responsibility of life-long learning and self-reflection.
- Improve own learning and peers' learning via peer-evaluations.

Attendance Policy

Attendance is mandatory and any absence will need to be made-up, whether it is an excused or unexcused absence. Excused absences may include (at the instructor's discretion): personal illness, family emergencies, or school-sponsored extracurricular activities. In order to be excused, you must contact the course director (by phone or email) prior to the lecture missed. Accommodations will then be made to make up the missed session. In addition, late arrival is unacceptable, as it fails to project a professional demeanor. Lecture will start each week with announcements and if you miss the announcements you will still be held responsible for the content.

Assessments and Grading

Assessments and Assignments

The following assessments and assignments will count toward your final grade for this course:

	Activity
Ambulatory Pharmaceutical Care Clinic Patient 1:	Patient Assessment
	Patient Case Presentation
	Documentation
	Peer Evaluation
Ambulatory Pharmaceutical Care Patient 2:	Patient Assessment
	Patient Case Presentation
	Documentation
	Peer Evaluation
2 Journal Clubs	Peer Evaluation
Final Lectures	Book Report/Reflection
Final Lectures	Course Reflection

Grading Information

1) No grades of "Incomplete" ("I") will be assigned in this class.*
2) Student may take the course on an A-F, or S-N basis.*
   Student grades will be based on expected behaviors that are attributed to a health care professional when responsible for providing patient care (appropriate to the student's level of competence): team based patient care, timeliness, and completeness. A student will receive a grade of "A", provided that the student fulfills the requirements listed below:

PharmD I students will receive a grade of "A", provided that the student:

Attends and participates in all required classes
Records patient information collected during the course of the patient assessment
Conducts appropriate patient assessment activities (ie. blood pressure readings, etc)
Assists in documenting care
Participates in the patient case presentation to peers in-class
Assembles resources on the patient's behalf
Participates in the development of a personalized care plan for the patient
Fulfills all documentation requirements in a professional manner (completeness and timeliness)
Completes self and peer evaluations by specified date
Submits the reflective paper of selective book by specified date
Submits the course reflection paper by specified date

Pharm.D. II and III students will receive a grade of "A", provided that the student:

Meets all requirements listed for Pharm.D. I students, as well as:

Conducts an appropriate assessment of a patient

Prepares a physician letter outlining patient interaction and proposed plans

Conducts a follow-up evaluation at the time mutually established between the patient and the student during the initial pharmaceutical care encounter

4) Student grades will be reduced if the above criteria are not met. Grade reductions can accumulate and will occur as follows;

One full grade (i.e. A to B, B- to C-, etc.) if the student neglects to arrive on time for a patient appointment, is dressed inappropriately, or exhibits a behavior that would compromise patient care.

One full grade for not participating in group case presentation

One-half grade reduction for each day that the patient's personalized pharmaceutical care plan and/or physician letter is past due.

One-half grade reduction for incomplete documentation on final letters

One-half grade reduction for not meeting deadline for signing final documentation/letters

One-half grade reduction (i.e. A to A-, A- to B+, etc.) for failure to conduct a follow-up evaluation as scheduled with the patient

One full grade reduction (i.e. A to B, B to C, etc.) for each day that the reflective papers are past due.

* The Course Director reserves the right to make allowances for any catastrophic or extenuating circumstances that could possibly affect students, contingent upon appropriate documentation by the student.

Clinic Structure and Assessment Flow Information:

Third professional year and most second professional year pharmacy students provide care to the patient.

All students will be present (dressed in professional attire) at least 15 minutes prior to patient appointments, and will wear laboratory coats and name badges.

First year students observe care delivered to the patient, ask additional assessment questions at the conclusion of the assessment, and serve as care plan and documentation team members.

Faculty observer responsibilities are to:
i) Provide information support, if requested by the student during the course of the assessment.
ii) Discourage student recommendations that may be detrimental to the health of the patient.
iii) Obtain additional information from the patient at the conclusion of the assessment for the purpose of improving the student's assessment of the patient's drug-related needs (i.e. to clarify patient treatment goals and identify any other drug therapy problems).
Other observers may be present pursuant to patient and student consent.

Patients are instructed to bring a medication list and, to bring ALL medications, remedies, supplements, etc.
Patient completes informed consent and patient privacy (HIPAA) requirements.

A common patient care process (assessment, care plan and evaluation) is used to care for all patients.

Assessment, Care Plan, and Evaluation Flow Description:

Initiate a therapeutic dialogue (introduce self, explain pharmaceutical care, determine patient concerns, expectations, understanding of health and use of medications).

Review all medications/remedies, for indication, effectiveness, safety & convenience.

Conduct a verbal review of systems to identify any other drug-related needs.

Observer/care plan team member asks additional assessment questions, if any.

Faculty observer probes for additional drug therapy problems, if any.

Student reviews mutually-agreed upon care plan responsibilities with the patient.

Student sets follow-up evaluation appointment with the patient.

Patient is asked to discuss and critique the student's patient care assessment skills.

Faculty observer collects patient contribution, if any.

Patient departs.

Student is asked for their self-evaluation (comment and critique their own performance immediately following patient departure) if time is allowed.

Faculty feedback:
Faculty observer and student(s) review patient conditions, medications, and drug therapy problems (RBRVS criteria).
ii) Evaluate student's performance within the seven patient care process criteria
(Patient care process criteria attached as Appendix "A").
Student fulfills their care plan responsibilities and documents care.
Student executes follow-up (on the phone or in-person, faculty presence not necessarily required, but available upon request of the student).
Student reviews the patient's personalized care plan with faculty, obtains a co-signature on the care plan.

Patient Care Process Criteria:

The criteria utilized to evaluate the student's performance within the patient care process are:

Ascertaining and documenting the patient's understanding, concerns and expectations about their drug-related needs,

Linking each of the patient's active medications/remedies to an appropriate medical indication,

Determining the goals of therapy for each of the patient's medical conditions,

Assessing the patient for the presence of drug therapy problems related to the indication, effectiveness, safety and convenience of medications,

Probing for additional drug therapy problems through a review of systems,

Establishing a mutually agreed-upon care plan, and

Following-up with an evaluation for every patient.

Note: Grades are not assigned based upon performance within the patient care process criteria. These criteria will be discussed between students and faculty observer at the conclusion of the patient assessment so that the student may self-evaluate their strengths and areas of improvement relative to the patient care process.

Abbreviated Practitioner Case Presentation Outline:

A. Brief description of the patient, reason for the encounter, and specific patient concerns
B. Patient background, past medical history and significant medication experiences
C. Current medical problems
D. Active medication list
E. Review of systems
F. Summary of drug therapy problems
G. Care plan description
H. Evaluation parameters (including actual outcomes when known)

Book/Class Reflective Papers and Discussion

The objective of this portion of the course is to create awareness of how an individual's experiences may affect their health care choices. To receive credit for this activity, the student must:

Select, receive confirmation from instructor, and read 1 Non-fiction books whose topics are related to health care concerns (subject to instructor approval).

Write a three-to-four page reflective paper about the book (double-spaced, 12 point font) and submit to the instructor by the dates specified below.

Write a three-to-four page reflective paper about the impact of the class. The purpose of the final course paper is for the student to reflect upon care delivered to patients in the class, and how this experience is expected to help the student prepare for serving as a pharmaceutical care practitioner in the future.

Be prepared to discuss the papers during the final class of the semester

Statement on Extra Credit

No extra credit will be offered in this course.

Ambulatory Patient Care Clinic Outline/Sequence – Student Reference

First Day of Class: Patient Assessment and Documentation Review

a. Overview and Expectations of Course
b. Documentation
c. Discuss Patient Assessment Techniques

Week 2: Patient Clinic Appointment

a. Students should arrive 15 minutes before the first appointment to assure readiness of materials, etc.
b. **Patient Assessments to last 45 minutes**. Recommended scenario for students: P3 Student is lead interviewer with P2s filling in and P1s conducting BP/Pulse measurement.
c. Spend 10 minutes giving the students feedback and discussing next steps/questions. If the assessment goes over 45 minutes and up to an hour, the students must be cut off at one hour and time will not allow for verbal feedback.
a. Evaluation rubrics are provided and available on Moodle.

Week 3: Patient Case Presentations

b. Groups will present to fellow classmates. **Presentations should be no longer than 20 minutes with 10 minutes for feedback and clinical discussion** as a group. P1 students are the lead presenters (other group members take notes and add verbal info as needed).
c. Evaluation rubrics are provided and available on Moodle.

Week 4: Documentation

a. **Documentation should be emailed to bast0067@d.umn.edu at least 4 hours before the documentation meeting. Reminder: DO NOT use any patient identifiers.** Meet during class hours to discuss any changes needed to documentation
b. **Final documentation is due as assigned by course instructor**.
c. Students will receive an email notification from Anna Firoozi for deadline of signature on final letters.
d. Evaluation rubrics are provided and available on Moodle.
e. Final grading is based on student professionalism and ability to meet deadlines.

Schedule*

Week	Lecture	Ambulatory Care Clinic**
Dates: TBD Week 1	Course Introduction and Overview	N/A
Week 2	Documentation and Adherence	N/A
Week 3	N/A	Patient Care Groups: 1 - 4
Week 4	Patient Case Presentations and Discussion	N/A
Week 5	Guest Lecturer: Local MTM provider Documentation Reviews	N/A
Week 6	N/A	Patient Care Groups: 5 - 9
Week 7	Patient Case Presentations and Discussion	N/A
Week 8	Guest Lecturer: Local MTM provider Documentation Reviews	N/A
Week 9	Patient Care Follow-up Reports	N/A
Week 10	SPRING BREAK	No class
Week 11	APhA	No class
Week 12	N/A	Patient Care Groups: 10 - 14
Week 13	Patient Case Presentations and Discussion	N/A
Week 14	Documentation Reviews Patient Care Follow-up Reports	N/A
Week 15	Reflective Papers Due Final Course Wrap-up	N/A

* Subject to change at course director's discretion. Refer to separate schedule available on course website.
** See Lab Groups and Lab Schedule to determine individual requirements (variable, dependent on course enrollment)

EVALUATION TEMPLATE – 6230 PC Clinic Pt Assessment

Evaluation Component	Ratings				Comments
	Potentially detrimental to patient care	**Needs improvement**	**Professionally acceptable**	**Exceptional**	
Establish therapeutic relationship • Introduction to the patient • Provide a brief description of your purpose/pharmaceutical care • Obtain patient's consent	Steps to establish a therapeutic relationship are performed in a manner that may result in a lack of trust OR a negative relationship with the patient	One of the pieces necessary to establish a therapeutic relationship with the patient is not performed OR is not patient friendly	Introduction to patient, description of pharm. care and attainment of patient consent is completed and performed in a patient friendly manner, but is not very well-organized or articulate.	Introduction to patient, description of pharm. care and attainment of patient consent is completed, well-organized, articulate and performed in a patient-friendly manner	
Determine patient's reason for presenting today • Determine patient's perception of drug-related needs • Use of open-ended questions to uncover patient's reason for presenting	Patient's chief concern is not questioned OR patient's reason for presenting is addressed, BUT in a way that may be misconstrued and detrimental to patient care	Student does not completely uncover patient's reason for presenting OR student infers patient's reason for presenting based on closed ended questioning	Student completely discovers patient's reason for presenting, BUT does not do this efficiently or use open-ended questions effectively	Student discovers patient reason for presenting completely and in an efficient manner through the effective use of open-ended questioning	
Identify specific drug-related needs the patient may have • Allergies • Alerts/Adverse Drug Reactions • Concerns/questions	Student fails to question patient on allergies, alerts/ADRs OR concerns/questions	Student questions patient on specific drug-related needs, but does not clarify the nature of allergies or alerts	Student completely discovers patient's specific drug-related needs, BUT does not do this efficiently OR use open-ended questions effectively	Student discovers patient's specific drug-related needs and in an efficient manner through the effective use of open-ended questioning	

Establish Current Health Status • Determine patient's current medical problem list • Identify drug therapies associated with each medical problem/dosage instructions • Establish brief history/current status of medical conditions • Perform physical assessments appropriate for patient's current health status and drug therapy use • Question the patient about their goal(s) for therapy	Student fails to identify drug therapies associated with each medical problem OR prescribed dosage instructions OR does not reconcile patient's current medical problem list OR fails to perform BP and P.	Student identifies drug therapies, medical problems, and prescribed dosages AND checks at least BP and P, BUT does not establish brief history of the condition or patient's goals for therapy OR fails to perform additional physical assessments indicated in this patient.	Student establishes current health status completely, BUT may not do this in a way that is efficient and effective for patient care	Student establishes patient's current health status in a complete, efficient and effective manner	
Assess for Drug Therapy Problems For each medical problem/medication investigate... • Whether there is an indication for additional or current drug therapy • Effectiveness of current drug therapy • Safety of current drug therapy • Convenience of current drug therapy	Student does not cover more than one of the parameters related to drug therapy for all drug therapies.	Student may question patient regarding each of the parameters related to drug therapy, BUT fails to do so for each drug therapy OR student completely fails to use open and close-ended questions with patients appropriately.	Student completely assesses patient for drug therapy problems, BUT does not do this in a way that is efficient and effective for patient care.	Student completely assesses patient for drug therapy problems in an efficient and effective way appropriately using open and closed-ended questions	
Review of Systems • Perform a complete ROS	Student does not complete a ROS to any extent	Student begins to address ROS, but does not do so in a complete manner	Student performs a complete ROS, but does not use open-ended questions appropriately or peform this effectively.	Student performs a complete ROS appropriately and effectively.	

Plan for Follow-up • Obtain patient consent • Explain method and time frame with the patient • Outline the parameters that would be discussed	Discussion of follow-up omitted, inappropriate OR is outside of the practice allowed for students	Student does not obtain patient consent for follow-up OR confirm patients understanding OR does not mention a time frame for follow-up	Student completely discusses follow-up with the patient, but does not effectively outline the parameters that will be discussed in follow-up	Student completely and effectively addresses follow-up with the patient.	
Use of terminology • Avoid use of terminology unfamiliar to the patient	Student uses terminology that obviously confuses the patient and interrupts the patient assessment.	Student uses unfamiliar terminology greater than 3 times during the visit AND fails to explain this terminology when using it.	Student uses unfamiliar terminology 1-2 times during the visit AND fails to explain this terminology when using it.	Student uses no unfamiliar terminology OR adequately explains each use term to the patient.	
Communication Skills • Communicate in a manner that was understood by the patient • Confirm patient understanding • Summarize information and/or the assessment • Speak at an appropriate volume • Has no distracting non-verbal cues • Display appropriate empathy	Student communicates with the patient in a way that negatively impacts patient care.	Student appears to not be understood by the patient OR confirm patient understanding OR summarize for the patient OR speak at an appropriate volume OR has distracting non-verbal cues without correction during the visit.	Student communicates sufficiently with the patient, but may need reminders to speak up and re-explain something OR could better summarize the visit and confirm patient understanding.	Student displays outstanding communication skills for patient care.	
General Interview Skills • Follow a clear and logical line of questioning • Demonstrate efficiency in interviewing • Ask relevent and useful questions	Student interviewing skills are so erratic and irrelevant that patient care is not possible	Student displays interviewing skills that includes unclear and irrelevant questioning OR student is not effective in interviewing.	Student has good interviewing skills, BUT could improve line of questioning and replace some unuseful questions	Student's interviewing skills are consistent with high quality patient assessment.	

EVALUATION TEMPLATE – 6230 Case Presentations

Evaluation Component	Ratings				Comments
	Potentially detrimental to patient case	Needs improvement	Professionally acceptable	Exceptional	
Brief Description of the Patient Should include how the patient appears to the practitioner, patient's age, gender and physical description	Student does not provide any patient description OR patient confidentiality is not maintained	Student misses piece of patient description	Description of patient is complete, BUT is not done in a simple, straightforward manner	Description of patient is complete in every detail and is performed in a simple, straightforward manner	
Reason for Pharmacist Patient Encounter Should focus on the patient's initial request or the precipitating event including signs, symptoms or description of general health	Student does not provide any reason for patient encounter without explanation of why this wasn't attained	Student includes information not pertinent to the reason for the pharmacist-patient encounter	Reason for pharmacist-patient encounter is complete, BUT does not describe the patient's perception of need	Reason for pharmacist-patient encounter is complete AND comprehensive AND includes the patient's perceptions (including such things as patient quotations)	
Patient Background Covers all factors that impact the patient's drug taking beliefs, behaviors and outcomes, functional capacity and description of any special needs	Patient background is not covered or is presented in a manner that is not politically sensitive without an appropriate explanation.	Patient background is not covered in sufficient detail to understand patient's drug taking beliefs, behaviors and outcomes.	Patient background is presented completely, but includes information not pertinent for the purposes of presenting a case	Patient background is complete, accurate and pertinent to understanding the care of the patient	

History of the Present Illness (Indication for Drug Therapy) Describe the presenting concern(s), how patient is affected, onset, duration, patient's perception, past treatment attempts	HPI is not discussed or is presented in a manner that does not provide sufficient information supporting patient care without an explanation of why not covered.	HPI is presented but is missing components such as onset and duration or patient's expectations.	HPI is presented, but unnecessary information is presented OR student is unable to completely describe patient's treatment history	HPI is presented accurately and completely and includes only pertinent information.	
Current Medical Problem List Describe ALL the patient's medical conditions requiring treatment and describes if and how they are being treated. Include relevant lab values.	Medical Problem List is not presented.	Medical Problem List is presented, but pertinent lab information is missing without explanation OR conditions are not described in the context of affecting drug therapy	Current Medical Problem List is discussed, BUT information presented is not pertinent to this section OR is not current	Current Medical Problem List is presented accurately and completely and includes only pertinent information.	
Medication Record Connects medical problems with drug therapy taken.	Medication Record is not presented OR does not include information such as dosage regimen	Medication Record is presented, BUT does not connect medical problems with drug therapy OR is not organized by therapeutic indication	Medication Record is complete, BUT contains information not pertinent to this section of the presentation	Medication Record is complete, accurate and only contains pertinent information.	
Allergies and Alerts Describes Allergies, ADRs, Social History, Immunization History	Allergies and Alerts are not presented.	Allergies and Alerts are presented however nature of allergies and ADRs are not presented OR social history is missing OR immunization history is missing	Allergies and Alert section is complete, BUT contains unnecessary information for this section	Allergy and Alerts are complete, pertinent and accurate in every way	

Past Medical History Brief discussion of pertinent past problems related to drug therapy	Pertinent Past Medical History is not presented without an adequate explanation.	Past Medical History described elsewhere is presented again OR includes information that is current OR is incomplete	Past Medical History presented is not pertinent to this section (not related to drug therapy) OR does not include timing of PMH.	PMH is complete, pertinent and accurate in every way.	
Review of Systems Present pertinent information from the ROS.	ROS not presented OR is not explained why ROS was not completed	ROS is not presented in a productive manner OR is not reported systematically	ROS is complete, BUT is not presented concisely and usefully	ROS is complete, concise and useful	
Drug Therapy Problem Determination Describe the drug therapy problems identified	DTP section of presentation is not performed.	DTPs mentioned are incorrect OR DTPs are not appropriately categorized OR DTPs that are evident are missed	DTPs are complete, but preventable future DTPs are not mentioned	DTPs are presented accurately and completely.	
Summary of the Assessment Brief review of your clinical judgement and assessment	Summary of Assessment is not attempted	Summary of Assessment does not mention pertinent pieces of the assessment that are the focus of the care plan OR does not mentioned DTPs and associated drugs and medical conditions	Summary of Assessment is performed, BUT contains information not pertinent to this section	Summary of Assessment is complete, accurate and pertinent in every way.	
Establish goals of therapy Means by which to evaluate effectiveness of therapy.	Goals of therapy are not mentioned OR are incorrect potentially resulting in a negative patient effect.	Goals of therapy are addressed, but do not include specific measures OR a time frame to achieve goals of therapy	Goals of therapy are mentioned and correct, but may be unrealistic in regards to outcome or time frame	Goals of therapy are complete and accurate in every way	

Resolution of drug therapy problems Plan devised to resolve identified drug therapy problems and achieve established goals of therapy.	Resolution of DTPs is not attempted OR proposed resolutions may result in harm to the patient.	Resolution of DTPs do not link to the goals of therapy OR do not mention specific interventions (including dosing, etc)	Resolution of DTPs is complete, BUT does not mention other plausible alternatives OR is not the most effective resolution that could be proposed at this time	Resolution of DTPs is complete and accurate in every detail and consistent with the highest quality patient care.	
Plan to prevent drug therapy problems Identify steps and goals to prevent possible future drug therapy problems	Plan to prevent DTPs is not mentioned OR plan proposed may result in harm to the patient	Plan to prevent DTPs does not mention goals for prevention OR specific interventions to prevent DTPs	Plan to prevent DTPs is complete, BUT interventions may not be the most appropriate	Plan to prevent DTPs is complete and accurate in every way.	
Plan for follow-up When should patient be followed up with for these recommendations and what will be reviewed at that time?	Plan for follow-up is not complete OR proposed follow-up may be detrimental to patient care	Plan for follow-up is mentioned, BUT may not include such details as time frame and parameters for follow-up	Plan for follow-up is complete, BUT interventions may not be the most appropriate	Plan for follow-up is complete and accurate in every way.	
Summary of Case Present a very brief summary of the most relevant points of the case.	Case summary is not presented	Case summary fails to highlight the most relevant points of the case related to DTPs to be resolved.	Case summary is complete and accurate, but may contain information that is not necessary	Case summary is complete, accurate and pertinent in every way.	
Communication Skills	Communication skills are not conducive to any effectiveness in presenting a case	Presentation is jumbled or filled with many distracters	Communication is appropriate and will be improved with further case presentations OR questions are not answered appropriately	Communication skills are exceptional and the ability to answer case questions is exceptional	

EVALUATION TEMPLATE – 6230 PC Clinic Patient Letter

Evaluation Component	Comments			
	Needs improvement	Professionally Acceptable	Exceptional	Comments
Introduction	Introductory statement is not included	Introductory statement is complete and acceptable		
Conditions	One or more of the patient's conditions are NOT addressed in the patient letter	All the patient's conditions are addressed in the patient letter		
Goals of Therapy	Goals of therapy are missing for one or more conditions OR are not consistent with appropriate patient care	Goals of therapy are complete, BUT minor omissions are made	Goals of therapy are complete AND accurate in every way	
Drug Therapy Problems	Drug therapy problems are not appropriately identified OR lack rationale to support the identification of the drug therapy problem	Drug therapy problems are appropriate but minor omissions are made OR contain suggestions for the patient	Drug therapy problems are complete and accurate in every detail	
Suggestions and Monitoring Plan	Suggestions and Monitoring Plan are not consistent with appropriate patient care OR are inconsistent with established guidelines w/o explanation OR is otherwise clinically inappropriate	Suggestions and Monitoring Plan are appropriate but have minor omissions OR contain further goals/drug therapy problem information	Suggestions and Monitoring Plan are complete and appropriate in every detail	
Grammar/Structure	Letter contains more than three grammatical errors OR is inconsistent with example letter structure	Up to three grammatical errors AND structure consistent with example letter	No grammatical errors AND structure follows example letter	
Use of Patient Appropriate Language	Letter contains more than three instances were inappropriate terminology is utilized for patient communication	Letter contains 1-2 instances where inappropriate terminology is utilized for patient communication	No instances of inappropriate terminology exist in the letter	
Consistency with Physician Letter	Recommendations and problems identified in patient letter are NOT consistent with physician letter	Recommendations and problems identified in patient letter are consistent with physician letter		

EVALUATION TEMPLATE – 6230 PC Clinic Physician Letter

Evaluation Component	Comments			
	Needs improvement	**Professionally Acceptable**	**Exceptional**	**Comments**
Introduction and Patient Background	Information is inaccurate OR reason for patient visit is missing OR Patient Background, Social History or Allergies/ADRs are not addressed	All information provided is accurate but minor omissions are made OR non-relevant information is included	Information is complete, relevant and accurate in every detail	
History of Present Illness	HPI is inaccurate OR HPI has major omissions that would make it unlikely another provider would have the same Impression or understand the proposed plan	HPI is accurate but minor omissions are made OR HPI contains Impression or Plan information	HPI is complete and accurate in every detail	
Current Medication List	Med List is incomplete OR inaccurate	Med List is complete and accurate in every way		
Impression	Impression is missing applicable patient goals OR fails to give an impression of each condition OR is missing/has wrong problem(s) stated OR is inconsistent with established guidelines w/o explanation OR is otherwise clinically inappropriate OR has major omission that would make it unlikely another provider would come to the same Plan	Impression is appropriate but minor omissions are made OR impression contains the Plan	Impression is complete and accurate in every detail	
Plan	Plan is missing specific recommendations (drug/dose/frequency, timeframe for action) OR is not consistent with the Impression OR is inconsistent with established guidelines w/o explanation OR is otherwise clinically inappropriate	Plan is appropriate but has minor omissions OR Plan contains further Assessment information	Plan is complete and appropriate in every detail	
Grammar/Structure	Letter contains more than three grammatical errors OR is inconsistent with example letter structure	Up to three grammatical errors AND structure consistent with example letter	No grammatical errors AND structure follows example letter	

Phar 6230 Self/Peer Evaluation

Student Name: _____

Please turn in this evaluation to my mailbox by 3:00pm, Friday

On a scale from 1-10, **1 representing NEVER** and **10 representing ALWAYS**, rank your group members (including yourself) on the following activities:

Group Members	**Meets to discuss**	**Contributes to problem solving**	**Contributes to correspondence**
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____

Please respond to the following statements regarding your experiences with the clinic patients for this clinic session. For the statements below, the numbers indicate 1= strongly disagree, 2= disagree, 3= neutral, 4= agree, 5= strongly agree

Group Dynamics:

1. Members in the group contributed equally throughout the 3 weeks	1	2	3	4	5
2. Case presentation was developed as a group	1	2	3	4	5
3. Patient and Provider documentation developed as a group	1	2	3	4	5
4. Disputes within the group were resolved easily	1	2	3	4	5

Comments/Suggestions: