University of Wisconsin-Madison
School of Pharmacy

728-741

School of Pharmacy
UNIVERSITY OF WISCONSIN–MADISON

Ambulatory Pharmaceutical Care Clerkship

2024 – 2025

Course Manual

728-741
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First Developed by the School of Pharmacy 1992

Course Description

Ambulatory Pharmaceutical Care Clerkship (728-741)
6 Credits

Definition
Ambulatory care pharmacy practice is the provision of integrated, accessible health care services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community. The ambulatory care setting involves interprofessional communication and collaboration to provide acute and chronic patient care that can be accomplished outside the inpatient setting.

Essentials for Practice and Care
The purpose of this course is to emphasize the essentials for practice and care in the ambulatory setting. The essentials for practice and care include providing patient-centered care, managing medication use systems, promoting health and wellness, and describing the influence of population-based care on patient-centered care.

1. **Patient-centered care –** provide patient-centered care as the medication expert (collect and interpret evidence, prioritize, formulate assessments and recommendations, implement, monitor and adjust plans, and document activities).
2. **Medication use systems management –** manage patient healthcare needs using human, financial, technological, and physical resources to optimize the safety and efficacy of medication use systems.
3. **Health and wellness –** design prevention, intervention, and educational strategies for individuals and communities to manage chronic disease and improve health and wellness.
4. **Population-based care –** describe how population-based care influences patient-centered care and the development of practice guidelines and evidence-based best practices.

Approach to Practice and Care
In addition, students will utilize skills when approaching practice and care in the ambulatory setting. These skills include solving problems, education and advocating for patients, collaborating, recognizing social determinants of health, and effectively communicating verbally and nonverbally.

1. **Problem solving-** identify problems; explore and prioritize potential strategies; and design, implement, and evaluate a viable solution.
2. **Education –** educate all audiences by determining the most effective and enduring ways to impart information and assess learning.

3. **Patient advocacy –** represent the patient's best interests.
4. **Interprofessional collaboration –** actively participate and engage as a healthcare team member by demonstrating mutual respect, understanding, and values to meet patient care needs.
5. **Cultural sensitivity –** recognize social determinants of health to diminish disparities and inequities in access to quality care.
6. **Communication –** effectively communicate verbally and nonverbally when interacting with individuals, groups, and organizations.

Pharmacists' Patient Care Process – students will provide patient-centered collaborative care as described in the *Pharmacists' Patient Care Process* (PPCP) model endorsed by the Joint Commission of Pharmacy Practitioners.

Evaluation & Grading

Grading Summary

This course requires a minimum score of 70% to receive a passing grade.

A	93-100
AB	89-92
B	83-88
BC	77-82
C	70-76
D	60-69
F	Less than 60

Grading Rubric

Course grades are determined according to the following weighting:

Student Performance Evaluation	
Midpoint	Required
Final	50%
Patient Care Assignments	
Patient Profile Review (5 = 10%) Medication Therapy Management (15%)	25%
Clinical Communication Assignments	
Case Presentation (10%) Journal Article Review (10%) Collaborative Practice Agreement Review (5%)	25%
Self-Evaluation	
Student's Rotation Self-Evaluation	Required
Other	
Student Profile APPE Seminar Preceptor, Site & Course Evaluations Reflection Document iTOFT Evaluation	Required
Experiential Checklist	Optional

See the 741 Grading Record for a summary of where to submit and how to score each activity.

Assignments

Student Performance Evaluation by Clinical Instructor (50%)

Explanation: Although frequent feedback will be provided to students by clinical instructors, student performance in this course will be formally evaluated at the midpoint and at the end of the clerkship.

Expectations: The clinical instructor with use the Midpoint evaluation to provide formative feedback on student performance at the 3-week point in the course. The Final evaluation will factor into the student's course grade.

Evaluation: The clinical instructor will use the online SPE form to evaluate the student. The score will be entered in the Grading Record. Grades will not be reported to the Registrar's Office until the evaluations are complete. See the Student Performance Evaluation in the General Manual for more information.

Patient Profile Review Using the PPCP (10%)

Explanation: This assignment serves as a guide for developing profile review skills necessary for practice as a registered pharmacist.

Expectations: Students are required to complete five (5) patient profile reviews (see sample form). Profile reviews should be assigned by the clinical instructor (approximately every week) and completed without the use of computerized drug-use-evaluation software. Students should review profiles utilizing the Pharmacists' Patient Care Process (five steps) and at least five different evidenced-based guidelines. Students should know the number of profile reviews is a minimum and students may have the opportunity to review additional profiles to gain greater experience.

Please note: students may use the documentation format available at the site rather than the sample form.

Please:

- refer to the Patient Profile Review Page for additional information.

- check the 741-course web page for resources.
- follow HIPAA guidelines located in the Experiential Education Policies when completing this activity.

Evaluation: The clinical instructor will review the patient profile reviews and discuss findings with the student. The clinical instructor will evaluate the completeness of the patient profile reviews using the Patient Profile Review Evaluation Form included in the Appendices.

Scoring of the activity will encompass three major domains:

1. Completeness of the database. (This is the collect phase of the Pharmacists' Patient Care Process.)
2. Thoroughness of the drug-related and medical-related problems requiring monitoring. (This is the assess phase of the Pharmacists' Patient Care Process)
3. Progress notes. (This includes the plan, implementation of the plan, and monitoring phases of the Pharmacists' Patient Care Process.)

See the Patient Profile Review Evaluation Form Rubric for information about grading this activity.

- Students may document using the format of the 741-practice site. Documentation forms will not be turned in to the School. Students **MUST** keep a copy of the documentation forms. Please follow HIPAA guidelines for this activity.
- Students will upload the Patient Profile Review Using the PPCP – Evaluation Form completed by the clinical instructor on the 741- course web page.
- The clinical instructor will enter the scores on the online grading record.

Medication Therapy Management (15%)

Explanation: Per APhA – *Medication therapy management, also referred to as MTM, is a term used to describe a broad range of health care services provided by pharmacists, the medication experts on the health care team. As defined in a consensus definition adopted by the pharmacy profession in 2004, medication therapy management is a service or group of services that optimize therapeutic outcomes for individual patients. Medication therapy management services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs and many other clinical services. Pharmacists provide medication therapy management to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing and resolving medication-related problems.*

Students will complete medication therapy management services (MTM) during the Ambulatory Pharmaceutical Care Clerkship. This activity will provide student pharmacists experience with intervention-based services, comprehensive medication reviews, and notifying health care providers with clinical recommendations. The goal of this intervention-based service is to assist two patients to improve their medication adherence.

Expectations:

1. During the required 741 APPE rotation, students will complete a **minimum** of **two** focused adherence interventions. Students, with the help of the clinical instructor, should identify two patients who would benefit from a targeted adherence consultation. Students will document the consultations using the usual platform at the practice site.
2. During the required 741 APPE rotation, students will complete a **minimum** of **four** Comprehensive Medication Review and Assessment (CMR/A) services. The goal of CMR/As is for students to review subjective and objective data, identify, and resolve drug therapy problems. See the drug therapy worksheet posted on the course web page for examples of drug therapy problems. Students will bill for the CMR/As per the usual process at the practice site. If a site does not bill for CMR/A services, the student is not expected to submit billing for the MTM services; however, the student is expected to complete at least one billing form. Please see below for information about the billing form. Students will document the CMR/As using the usual platform at the practice site.

   CMR/As will consist of the following steps:

   a. Medication Therapy Review – the student will collect patient-specific information, assess medication therapies for drug therapy problems, develop a prioritized list of drug therapy problems and create a plan to resolve drug therapy problems.
   b. Personal Medication List – the student will create a comprehensive list of the patient's medications including prescription, nonprescription, herbal, and supplements and provide it to the patient.
   c. Medication Action Plan – the student will create a medication action plan for the patient listing actions for the patients to use in tracking progress for self-management.
   d. Interventions and/or referral – as needed, the student will recommend interventions or referrals to other providers to optimize drug therapy.
   e. Documentation and Follow Up – MTM service is documented utilizing the usual process at the pharmacy practice site. A follow-up visit is scheduled based on the needs of the patient.

Sites use a variety of programs and platforms to support MTM documentation and billing. Platforms may be specific to the site or commercial products. An example of a commercial product typically used for eligible Medicare Part D members includes OutcomesMTM®. Another MTM program is the Wisconsin Pharmacy Quality Collaborative (WPQC) for eligible Wisconsin Forward Health (Medicaid) members. WPQC services may also be completed by participating in United Way of Dane County Medication Review events. Interested students should contact WSPS to participate in United Way of Dane County Medication Review events.

Students should inquire about which MTM platform is used at the site and complete the MTM platform training by the end of week one. Students will upload the training certificate or submit a paragraph describing the completed training if a certificate is not provided. All students are encouraged to become WPQC certified regardless of the platform used at the site. Of note, there is no cost for WPQC certification for students.

Please note: For students at 741 sites **participating** in the WPQC program:
If you are at a 741 site participating in the Wisconsin Pharmacy Quality Collaborative (WPQC), you are required to complete the WPQC training and upload the training certificate on the 741-course web page.

Please note: For students at 741 sites **NOT participating** in the WPQC Program:
If you are at a 741 site that is not participating in the WPQC program, you are required to complete the site MTM training and upload the training certificate or a parapgraph describing the training on the 741-course web page. In place of billing for the actual service, you will instead complete one billing form using the Information to Collect when Submitting WI Forward Health MTM Claims using the guidelines outlines in the WI ForwardHealth Provider Handbook. The billing form may be found on the course web page under MTM.

Sample MTM Platforms:

f. For information on Outcomes MTM®, please see https://www.outcomesmtm.com/pharmacy/
g. For information on WPQC, please see this link and the information found in the Resources of this manual.

Evaluation: The clinical instructor will evaluate the student's performance using the Student Performance Evaluation Tool.

h. Students will upload their MTM training certificate / documentation on the 741-course web page.

i. The Clinical instructor will enter the number of MTM focused adherence consults and CMR/As completed on the online grading record.
j. The Clinical instructor will enter scores on the Student Performance Evaluation under Domain 2 -Essentials for Practice assessing MTM skills.

Case Presentation (10%)

Explanation: The purpose is to allow students the opportunity to refine their skills in concisely presenting patients and provide the background for a therapeutic discussion.

Expectations: Students are required to present one oral case presentation to colleagues based on a patient receiving care at the APPE site. The case presentation should focus on **ONE** disease state and **ONE** drug therapy. Students will give a 30-minute formal verbal presentation using PowerPoint. Case presentation schedules for students in the Madison and Milwaukee regions may be found on the course web page. Students in other regions will present as assigned by the clinical instructor.

Please refer to the Case Presentation Activity Description for a case example and evaluation criteria.

Evaluation: Clinical instructors(s)/Faculty will evaluate the student's performance using the Case Presentation Evaluation Form also found in the Appendices.

k. Students will upload to the 741-course web page the case PowerPoint presentation and the completed Case Presentation Evaluation Form by 11:59pm on the last day of the block.
l. If the regional coordinator graded the case, students will provide the case evaluation to the clinical instructor so that he/she may enter the case score.
m. The clinical instructor will enter the score on the online grading record.

Journal Article Review (10%)

Explanation: The purpose of a journal article review is to facilitate the evaluation of current research findings and the implications for clinical practice.

Expectations: The steps for this activity include:

n. Reading the article, Finding Truth from the Medical Literature: How to Critically Evaluate an Article by William F. Miser, MD, MA, posted on the course web page.
o. Selecting and reading one journal article from primary or secondary literature. Be sure to share the article with your clinical instructor.
p. Completing the journal article template posted on the course web page to guide discussion preparation.
q. Discussing the article with your clinical instructor.

Evaluation: Using the journal article template, students will evaluate one article and complete the Journal Article Template Form. The clinical instructor will discuss the article with the student using the completed journal article template as a guide.

The clinical instructor will evaluate the student using the following scale:

	1 (Inconsistent)	**2 (YES)**
0 (NO)	Some deficiencies with	Acceptable. Sufficient
Not done or Unacceptable	information provided.	information provided

r. Students will upload to the 741-course web page the Journal Article Template Form by 11:59pm of the last day of the block.
s. The clinical instructor will enter the score on the online grading record.

Collaborative Practice Agreement (CPA) Review (5%)

Explanation: The purpose of the CPA review is for students to learn the legal requirements and the required components of a CPA.

Expectations: Students will develop a one or two page summary that includes:

t. A definition of collaborative practice
u. A definition of a collaborative practice agreement
v. A description of the regulatory requirements for collaborative practice agreements in the state of WI
w. A summary of one CPA in use at the practice site

See the Resources page for suggested references. Students will discuss their review with the clinical instructor.

Evaluation: The clinical instructor will evaluate the student using the following scale:

0 (NO)	**1 (Inconsistent)**	**2 (YES)**
Not done or Unacceptable	Some deficiencies with information provided.	Acceptable. Sufficient information provided

x. Students will upload the summary on the 741-course web page by 11:59pm of the last day of the block.
y. The clinical instructor will enter the score on the online grading record.

Student Rotation Self-Evaluation (Required)

Explanation: See the Student Rotation Self-Evaluation Process for details.

Expectations: The following is an overview of the process:

z. A BASELINE self-evaluation is done ONCE prior to the start of the first APPE rotation of the year. The baseline self-evaluation must be reviewed with the site clinical instructor during the first week.
aa. SMART Goals must be entered by the end of week 2.
bb. A post-rotation self-evaluation must be completed at the end of each rotation. It must be reviewed by the student and site clinical instructor during the last week of each block.
cc. In subsequent blocks, the post-rotation self-evaluation from the previous block must be reviewed with the site clinical instructor during the first week.

dd. Failure to complete the self-evaluation will result in an "incomplete" for the block.

Reflection Document

Students will write a paragraph reflecting on a learning opportunity or memorable professional development event that occurred during the rotation. Students will upload on the 741-course web page a copy of the reflection by 11:59pm of the last day of the block.

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iTOFT (Required)

Explanation: See the APPE Evaluations in the General Manual for a full description of the tool.

Expectations: Instructors will verify that the iTOFT evaluation is completed. The iTOFT evaluation is accessible from the grading record.

Evaluation: The iTOFT evaluation is required, but the evaluation score is not factored into the final course grade.

Resources

- The QuEST/SCHOLAR Process
- **Web Sites** (Students should check the 728-741 course web page for additional resources.)
  - Ebling Library
  - Department of Safety and Professional Services
  - ForwardHealth
  - ForwardHealth: Wisconsin Medicaid
  - ForwardHealth Portal
  - ForwardHealth Pharmacy Resources

    - ForwardHealth Pharmacy Updates and Handbooks
- **General Course References**
    - DiPiro JT, Talbert RL, Yee GC, Matzke GR, Wells BG, Posey LM. Pharmacotherapy: A Pathophysiologic Approach, Latest Edition. -or- Young LY, Koda-Kimble MA. Applied Therapeutics: The Clinical Use of Drugs, Latest Edition.
    - Clinical Clerkship Manual, Boh LE.
    - Handbook of Non-Prescription Drugs. APhA, Latest Edition. – or – Pray WS. Non-prescription Product Therapeutics. Philadelphia: Lippincott, Williams & Wilkins, 2006.
    - Harrison's Principles of Internal Medicine, Latest Edition. (Recommended)
    - USP DI Volumes IA, IB, & II
    - Drug Interactions-Facts, or other appropriate drug interaction reference
    - Drug Facts and Comparisons.
    - Poirer S, Buffington DE, Mernoli GA. Submitting Claims for Patient Care Services.
    - Bickley L. Bates' Guide to Physical Examination and History Taking, 8th Ed. Philadelphia: J.B. Lippincott, 2003. (Recommended)
- **Monitoring**
    - Hepler CD. Unresolved issues in the future of pharmacy. Am J Hosp Pharm. 1988;45:1071-81.
    - Hepler CD, Strand LM. Opportunities and responsibilities in pharmaceutical care. Am J Hosp Pharm. 1990;47:533-543.
    - Strand LM, Cipolle R, Morley PC. Drug related problems: their structure and function. Drug Intel Clin Pharm. In press, 1990.
    - Strand LM, Guerrero RM, Nickman NA, Morely PC. Integrated patient-specific model of pharmacy practice. Am J Hosp Pharm. 1990;47:550-4.
- **Medication Therapy Management**
    - WPQC Program Information
    - Wisconsin ForwardHealth Billing Resources
- **Collaborative Practice Agreement Review**
    - https://docs.legis.wisconsin.gov/2013/related/acts/294
    - http://www.cdc.gov/dhdsp/pubs/docs/Translational_Tools_Pharmacists.pdf
    - PSW Tool Kit for CPA
    - Article: "Consortium recommendations for advancing pharmacists' patient care services and collaborative practice agreements".

    - AMA – Embedding Pharmacists into the Practice.
- **Case Presentation**
    - References as determined by topic.
- **Drug Information**
    - References as determined by topic.

728-741 Experiential Checklist

(For Both Student and Clinical Instructor)

Student_____ Clinical Instructor_____

Block_____ Site_____

The accompanying checklist has been designed to help students become familiar with the ambulatory practice site and staff. It is intended to help formalize initial and ongoing communication between the student and clinical instructor (CI) and to help increase the comfort level of the student in his/her new surroundings. In addition, it provides a guide of when course activities should be completed. It is encouraged that the student and instructor review this checklist during the first week and as needed throughout the rotation. **This document is intended to be a guide and will not be submitted.**

Date Completed	Prior to Rotation
	1. Student contacts clinical instructor 2 weeks prior to start and updates student profile.
	2. Clinical instructor sends map/parking/bus schedule information to student if requested by student.
	3. Review unique health status requirements. Student should have copies of forms for sites needing actual documents.
	4. Discuss personal requirements (housing, nametag, white coat, calculator, background reading, etc.)

Date Completed	Week One of Rotation (arrange time to meet in uninterrupted environment)
	1. Give a schedule (hours to attend, etc.) to each other. Discuss workflow and student responsibilities.
	2. Review computer access, security system, and paging.
	3. Review library clearance, photocopying.
	4. Review patient medical records or patient profiles.
	5. Discuss policy and procedures, health policy, universal precautions, and site safety/robbery protocols. Discuss inclement weather policy. Discuss whom to call if student is ill.
	6. Introduction to all pharmacy staff and other personnel (i.e., tour unit or clinic, orient to store, etc.).

	7. Review available references.
	8. Assess student baseline knowledge and identify student interests.
	9. Review course and site objectives. Discuss goals based on student skill and experience.
	10. Discuss professional conduct, ethics, and confidentiality policies.
	11. Student reviews Student Performance Evaluation (SPE) History with instructor and identify student areas needing improvement.
	12. Discuss how many professional days have been used by block to date & what plans the student has this block for using any professional days. *Review clerkship policy regarding the use of professional days and attendance.* Any time missed excluding professional days must be made up.
	13. Couse Activities – Review course assignment deadlines. Review APPE seminar dates. Identify a patient for the case presentation with a focus on one disease and one drug. Identify a journal article to discuss.

Date Completed	**Continuous Throughout Rotation**
	1. Have conferences at appropriate intervals (no less often than weekly) between student and instructor.
	2. Give timely and specific feedback on “activities” (consultations, profile reviews, and presentations) when needed or when requested.
	3. Notify faculty coordinator immediately regarding students with poor attendance or performance.
	4. Course Activities - Review course assignment deadlines.

Date Completed	**Week Two of Rotation**
	1. Discuss and establish student’s SMART goals for the rotation and document in the Rotation SMART Goals.
	2. Course Activities – Identify an article to review for the journal article review.

Date Completed	**Week Three of Rotation** **(arrange time to meet in uninterrupted environment)**
	1. Schedule verbal evaluation stating accomplishments, problems and concerns; confirm or reset goals for remainder of rotation. Use Student Performance Evaluation (SPE) history and discuss progress.
	2. Course Activities - Course activities that should be completed at week three include 2-3 patient profile reviews, 2 CMRAs, 1 focused adherence intervention, and the CPA review.

Date Completed	**Week Five of Rotation**
	1. Course Activities – Students should be finishing the following assignments case presentation, 2 CMRAs, 1 focused adherence intervention, 2-3 profile reviews, and the journal article review.
	2. Schedule time to meet to review final evaluation.

Date Completed	**Last Week of Rotation** **(arrange time to meet in uninterrupted environment)**
	1. Student fills out Rotation Self-Evaluation, clearly and completely documenting strengths and weaknesses based on the evaluation criteria.
	2. Clinical instructor discusses and reviews with student: • Student Performance Evaluation • Rotation Self-Evaluation • Grading Record
	3. Student completes course/site/preceptor evaluations and Interprofessional Skills and Experiences Survey.
	4. Clinical instructor returns all assignment and evaluation materials to the student
	5. Clinical instructor, please remind the student to upload his/her assignments and complete course evaluations on the 741 course web page by 11:59pm of the last day of the block.
	6. Student returns computer access card, ID, etc.

Grading Record for 741

(Activities due at the end of the block unless otherwise noted.)

Activity	Where to Submit	Record Scores
Clinical Instructor Grading		
Student Profile (update and contact Clinical Instructor 2 weeks prior to start of block)	Student Clerkship Webpage	(Instructor Initials)
Experiential Checklist (reviewed only)		(Instructor Initials)
Student's Rotation Self-Evaluation (reviewed last week of block)	Student Clerkship Webpage	(Instructor Initials)
Clinical Communication Assignments		
Case Presentation (due date set by instructor)	Course Dropbox	(0–100)
Journal Article Review	Course Dropbox	(0-2)
Collaborative Practice Agreement	Course Dropbox	(0-2)
i**TOFT**	Instructor Submits	(Instructor Initials)
Student Performance Evaluation (SPE)		
Midpoint Evaluation (end of week 3)	Instructor Submits	(0–100)
Final Evaluation	Instructor Submits	(0–100)
Patient Profile Reviews		
Review #1	Course Dropbox	(0–12)
Review #2	Course Dropbox	(0-12)
Review #3	Course Dropbox	(0-12)
Review #4	Course Dropbox	(0-12)
Review #5	Course Dropbox	(0-12)
Medication Therapy Management		
Focused Adherence Interventions (enter number completed)	Course Dropbox	(0–2)
CMRAs (enter number completed)	Course Dropbox	(0–4)
School of Pharmacy Grading		
Course/Site/Preceptor Evaluations	Student Clerkship Webpage	(required)
Seminar (See General Manual)	See General Manual	(required)
Reflection Document	Course Dropbox	(required)
Rotation Hour Log	Course Dropbox	(required)

CASE PRESENTATION

Activity

Audience- Clinical instructor(s), colleagues, other members of the pharmacist department or team

Duration- a 20-25 minute verbal presentation followed by a 5-10 minute discussion. The maximum presentation time is 30 minutes. If exceeded, the presentation will be **stopped**.

Materials-create slides using a technology platform like PowerPoint. Confirm you are able to access your file at your site before your presentation day. Print these off to serve as a handout. Your references should follow the AMA guidelines.

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Presentation Outline

FORMAL PRESENTATION	**DISCUSSION ON THERAPY, RESPONSE, COUNSELING**
Goal is to provide enough pertinent background for a meaningful discussion. **Strict 25-30 minute time limit.** Give warnings: 2 min, **CUT!**	Led by presenting student. Answer questions from the students and clinical instructors. *(about 5 to 10 minutes)*
Patient Case - share background *(about 3 to 5 minutes)*	
Disease State *(about 5 minutes)* etiology pathophysiology/epidemiology symptoms physical findings diagnostic tests/labs (criteria or limits)	
Therapy (about 15 minutes) goals of treatment efficacy time course non- drug treatment mechanism / rationale extent of response drug treatment [Featured medication] mechanism / rationale time course and extent of response pertinent pharmacokinetics[route, starting dose, maximum dose, titration/range rationale] adverse effects/toxicity common adverse effects (and any pertinent rare effects) time course management administration issues alternative drugs mentioned rationale for selected drug Rationale for dose, route, interval	
Summary and Prognosis *(about 1 to 2 minutes)* Summarize the patient's condition compared to the classic case State the prognosis of the patient in qualitative terms	

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Detailed instructions

Presentation of the Patient Case

This purpose of this section is to tell the patient's story. It involves the traditional presentation of the patient to include the situation and background (subjective and objective) information**.** You must be in compliance with HIPAA Guidelines The goal of this portion of the presentation is to set the stage for the didactic presentation of the therapy of interest. *For Community Pharmacy sites provide all the appropriate patient data that is available or list what information is necessary and how this information would be accessed. Approximations are acceptable for Community Pharmacy sites.* Essential information to present includes:

A. Demographic data–age, sex, gender identity, race, weight, and service patient is on.
B. Chief complaint. Reason for patient's admission/meeting the patient
C. History--includes present illness (HPI), past medical history (PMH), social history (SH) and family history(FH).
Include surgical procedures and mention previous hospitalizations that have a direct effect on the present illness
C. Medications (include medications prior to admission for hospital cases) Include duration of treatment., Allergies and prior Adverse Drug Reactions--list information that was obtained during medication history. Identify allergic reaction, how treated, if patient rechallenged. Include immunizations.
D. Pertinent physical exam data. Include BMI. Example–Abnormal exam in a patient with congestive heart failure may include the presence of 3+ ankle edema, + HJR, + JVP, and presence of rales in both lung fields. Pertinent negatives should be included also. Example– Normal rate and rhythm in a patient admitted to rule out MI.
E. Pertinent laboratory values. Example–in a patient with anemia the data may include Hgb 8, HCT 25, MCV 75, MCHC 25, serum iron 30, TIBC 400. Again, pertinent negatives also. Include ranges of normal values and units. Include CrCl and LFT if available.
G. A list of the Patient's Problems. This can include conditions currently requiring intervention.

Discussion of Disease State

This section of the presentation should include a general discussion of the disease process including pathologic and physiologic changes, symptoms, physical examination findings and diagnostic tests used to evaluate the disease process. The goal of this section is to identify markers of the disease process and identify symptoms or other outcome measures that can be used to evaluate patient response. This foundation facilitates your discussion of drug therapy and monitoring parameters for both efficacy and toxicity. **Be sure to bring out relevant points from your patient's story**.

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Discussion of Therapy

The focus of the presentation is the use of the featured medication in the treatment of the disease highlighted in the case.

THERAPEUTIC GOALS: The therapy section should start with the goals of treatment. What changes in the disease state are we hoping to modify or cure? Identify the markers for response and adverse events, the target goals for change and the time frame in which improvement or cure can be expected. As these goals for treatment of a particular disease are not typically unique to the different drugs used in treatment, this section should encompass any of the drug(s) discussed below in this section. If there are differences in the modification of the disease process by different drugs this should be explained.

NON-DRUG TREATMENT: The mechanism and rationale for initial or complementary non-drug treatment of the disease state should be briefly mentioned. If treatment is initiated with non-drug therapy, the expected magnitude and time frame of response should be noted so that the audience will realize when it is time to start treating the disease pharmacologically.

DRUG TREATMENT: This portion of the therapy discussion should focus on 1 primary drug that is being used for the treatment of the disease as highlighted by the presented patient case. Items to be discussed should include:

a) mechanism of action / rationale / literature supporting drug use
b) time course and extent of expected response
c) pertinent pharmacokinetic points (e.g. route of elimination, half-life, etc.)
d) route, starting dose, maximum dose, titration/range rationale
e) adverse effects/toxicity
   common effects (& any pertinent rare/serious effects) time course
   management
f) administration issues (if pertinent idiosyncrasies are expected or observed)
g) alternative drugs mentioned. However, the focus of the presentation is on the primary drug and extensive elaboration should be avoided for the sake of time.

Comparison with the Classic Case and Estimation of Prognosis

Briefly, summarize the presentation of the patient highlighting features of the case that illustrate a classic or atypical presentation of this disease state. Some index of the prognosis of the patient should be stated. A litany of statistical outcomes is not as important as the potential outcomes and a feeling of the probability of these outcomes (e.g. a patient with Functional Class IV heart failure is not likely to live more than 5 years at best without a heart transplant).

To conclude relate this all back to your patient. Summarize the initial drug regimen for the therapeutic topic including the rationale, dose, route, dosing interval and anticipated duration of the featured drug. Any concurrent clinical conditions that resulted in an alteration of the starting dose (e.g. renal dysfunction, hepatic failure, etc.) should be mentioned along with the appropriate method of dosage adjustment. *For 740 students also include the hospital course.*

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Question & answers

For the last 5 to 10 minutes of the session, you will be expected to answer questions from the students and clinical instructors attending the student's case presentation. If you are an attendee consider asking clarifying questions and sharing your perspective from your clinical experience.

EXAMPLE OF CASE PRESENTATION

CONGENITAL SYPHILIS

DEMOGRAPHIC DATA: Patient is a female infant who was admitted to the hospital for probable congenital syphilis. Patient weighs 4.2 kg and measures 52.7 cm tall.

CC: Thick green nasal discharge and noisy breathing x4weeks.

HPI: Patient presents to the hospital with a thick green and purulent nasal discharge, occasional cough and noisy breathing which has been persisting for 4 weeks. She also has a diaper rash for one week. Patient is the result of a NSVD and had a normal PE at birth. She was discharged at two days of age. Patient was seen at two weeks of age at the clinic for complaints of nasal discharge and breathing difficulties. Her chest X-ray was unremarkable. Since her clinic visit, the nasal discharge turned from clear and thin to thick and green. Patient has also become quite fussy and "spitty" in the lastweek.

PMH: Unremarkable until two weeks of age.

SH: Patient lives with her 22 year old single mother

FH: Mother tested negative for syphilis in January (early pregnancy) and oneday after patient's birth. Mother developed a rash and lesions on the palms of her hands, soles of her feet, nipples, and genital area about 1 month ago and was tested positive for secondary syphilis at the DERM clinic on the same day patient was admitted. Mother reports having sexual intercourse with a new partner twice during pregnancy.

MEDS: None.

ALLERGIES: NKDA.

IMMUNIZATIONS: Patient has not received her 2 month DTP and OPV.

PE: VS: T 37.8; P 170 (121-179); RR 42 (30-36); BP 64/42 (87/68); Wt. 4.2 kg (3.9-6); Ht. 52.7 cm (52-60)

GA: Awake and alert, congested breathing but NAD, smilingand active.

HEAD: Head circumference 35.5 cm (35.5-40)

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EYES: PERRLA, EOMI

EARS: TM's clear

NOSE: Crusted discharge around nares, both nares patent.

THROAT: White exudate at back of throat and on tongue.

NECK: Supple, normal ROM.

LUNGS: CTA

CV: RRR, normal S1 and S2; no murmur.

ABD: Soft, NTND, no HSM.

GU: Normal female, erythematous maculopapular rash present with satellite lesions.

EXT: Moves all extremities, RROM, good strength and tone.

SKIN: No rash.

NEURO: Alert, Cranial nerves intact, deep tendon reflex 2+.

LABS: HEME: WBC 7 (5-19.5); RBC 3.2 (3.8); Hgb 11.1 (11.5); Hct 31 (35); MCV 96 (96) MCHC 36 (33); RDW 13.5 (12-15); Plt 391,000 (170,000-380,000).

ABS DIFF: Neutrophils 2100 (1000-9000); Lymphocytes 3900 (2500-16,500); Monocytes 630 (700); Eosinophils 210 (300); Basophils 70.

CSF: Nucleated cells 2; RBC 20; Neutrophils 2%; Lymphocytes 71%; Macrophages 26%.

CHEM AND LYTES: Not available

LFT'S: Not available

PROBLEM LIST: Congenital syphilis?
Oral thrush
Diaper rash

THERAPY INITIATED WITH: Penicillin G Sodium 200,000 units IV every 6 hours.
Nystatin Cream topically to diaper area four times a day.
Nystatin Suspension 1 ml (100,000 units) to each side of mouth four times a day.

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13. McEvoy GK; ed. AHFS Drug Information. Bethesda: American Society of Hospital Pharmacists; 1989:192-220.

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Student Name: _____

Date: _____ Time Start: _____ Stop: _____

CASE PRESENTATION EVALUATION FORM

SECTION/COMPONENTS	GRADING CRITERIA
I. PATIENT PRESENTATION: 20%	Total points for section _____ x (4.0) =
a. PATIENT PRESENTATION _____ Demographic data _____ CC _____ HPI _____ PMH _____ SH _____ FH _____ Immunizations _____ Med list _____ Allergies / Adverse Drug Reactions _____ Pertinent PE data _____ Pertinent labs w/eval _____ Problem list _____ Weeds out _____ Significant points _____ Pertinent negatives	0. No discussion. 1. Gives only a cursory introduction of patient and status. Two or more major omissions. 2. Presents CC, HPI, PMH, problem list, medication list, PE, FH, SH, and lab data on a disorganized manner. One major omission. 3. Presents CC, HPI, PMH, problem list, PE, medication list, FH, SH, lab data on an organized manner. No major omissions, but possible minor omissions. 4. Explains complete CC, HPI, PMH, problem list, medication list, PE, FH, SH, lab data evaluation. Verbally notes significant points including pertinent negatives related to disease state. No major omissions, but possible minor omissions. 5. Explains complete CC, HPI, PMH, problem list, medication list, PE, FH, SH, immunizations, lab data evaluation. Weeds out unimportant data. Assesses and discusses significant points and pertinent negatives related to disease state.
II. DISEASE STATE: 10%	Total points for section _____ x (0.67) =
a. PATHOPHYSIOLOGY/EPIDEMIOLOGY _____ Discusses _____ Confident _____ Discrete _____ Demonstrates understanding _____ Not overwhelming _____ Relates information to patient	0. No discussion. 1. Skims over pathophysiology with little discussion. Major misconceptions concerning disease state. 2. Explains pathophysiology hesitantly. Does not demonstrate understanding in parts of material, but is correct about most of it. 3. Explains pathophysiology, demonstrating a basic simplistic understanding. 4. Demonstrates good working knowledge of disease and its presentation as related to patient. 5. Explains pathophysiology with confidence and discretion of all material. Demonstrates an outstanding understanding of subject, relates to patient, and does not overwhelm audience.
b. SYMPTOMATOLOGY _____ Discusses _____ Confident _____ Discrete _____ Demonstrates understanding _____ Not overwhelming _____ Relates information to patient	0. No discussion. 1. Skims over symptomatology with little discussion. Major misconceptions concerning disease state. 2. Explains symptomatology hesitantly. Does not demonstrate complete understanding of material, but is correct about most of it. 3. Explains symptomatology, demonstrating a basic simplistic understanding. 4. Demonstrates good working knowledge of disease and its presentation as related to patient. 5. Explains symptomatology with confidence and discretion of all material. Demonstrates an excellent understanding of subject as related to patient, and does not overwhelm audience.
c. DIAGNOSTIC PARAMETERS _____ Discusses _____ Lab limits _____ Disease limits _____ New diagnostic tests	0. No discussion. 1. States diagnostic parameters minimally. 3. Discusses diagnostic parameters with no major omissions of criteria. Does not set limits for diagnostic data. 5. Discusses diagnostic parameters, sets lab and disease state limits. Discusses new diagnostic tests when applicable.

III. THERAPY: 40%	Total points for section _____ x (1) =
a. THERAPEUTIC OBJECTIVES _____ Discussed _____ Expectation of outcome	0. No discussion of therapeutic goals for therapy selected. 1. Vague discussion of therapeutic objectives for therapy selected. 3. Discusses therapeutic objectives for therapy selected. 5. Explains objectives of therapy discussed, including reasonable expectations of outcome in selected disease state.
b. NON-DRUG TREATMENT _____ Discussed _____ Usefulness _____ Time course	0. Not discussed. 1. Possible non-drug treatments are incomplete and/or inaccurate. 3. Possible non-drug treatments explained. 5. All-inclusive list of non-drug treatments discussed, including assessment of usefulness and time course.
c. MECHANISM OF ACTION/THERAPEUTIC RATIONALE FOR TOPIC DRUG _____ MOA discussed _____ Therapeutic rationale discussed _____ Confident _____ Discrete _____ Demonstrates outstanding understanding _____ Not overwhelming _____ Provides literature to support drug use	0. Not discussed. 1. Major misconceptions regarding the mechanism of action of therapeutic rationale. 2. Explains the mechanism of action and therapeutic rationale hesitantly. Does not demonstrate understanding of parts of material, but is correct about most of it. 3. Explains the mechanism of action and therapeutic rationale, demonstrating a basic simplistic understanding. 4. Demonstrates a good working knowledge of the mechanism of action and therapeutic rationale. 5. Explains mechanism of action and therapeutic rationale with confidence and discretion of all material. Demonstrates an excellent understanding of subject and does not overwhelm audience. Provides literature to support drug use.
d. EFFICACY MONITORING _____ Parameters discussed _____ Limits set _____ Onset _____ Duration	0. No parameters for efficacy noted. 1. Parameters for efficacy noted--some inappropriate and irrational. 3. Parameters for efficacy noted and appropriate. 5. Parameters for efficacy noted and limits set, including onset and duration of expected response, if appropriate.
e. ADVERSE DRUG REACTION (ADR) MONITORING _____ Parameters discussed _____ Incidence _____ Limits set _____ Time span _____ Management	0. No parameters for ADR noted. 1. Parameters for ADR noted--some inappropriate and irrational. 2. Some parameters for ADR noted. 3. Major parameters for ADR noted and incidence described (common versus rare). 5. All parameters for ADR noted, incidence described (common versus rare), limits set, time span outlined, and management included.
f. INDIVIDUALIZING DOSAGE REGIMEN _____ Discusses _____ Renal _____ Starting dose _____ Hepatic _____ Max dose _____ Titration _____ PK methods	0. No discussion of dosing. 1. Dosage individualization not mentioned--only standard dose stated OR individualization is incorrect. 2. Starting and max doses stated. Drug does not require individualization, but student does not state such. 3. Discusses circumstances necessitating dosage change (e.g., renal, hepatic, etc.), however, no explanation of <u>how</u> to adjust doses. 5. Explains circumstances necessitating (e.g., renal, hepatic, etc.), and mechanisms for dosage individualization (e.g., starting and maximum doses, titration, and pharmacokinetic methods as applicable).
g. ADMINISTRATION ISSUES _____ Discussed, including unique issues _____ Route _____ Rate _____ Interactions _____ Incompatibilities _____ Prevention _____ Management	0. No assessment of the parameters. 1. Inadequate or inaccurate assessment of any parameter. 2. Few parameters are discussed and accurate. Minimal information discussed. 3. Most parameters are discussed and accurate. 4. Complete and accurate discussion of all parameters. 5. Comprehensive, complete and accurate discussion of all parameters: route, rate, interactions, incompatibilities, and drug-specific issues. Includes materials for prevention and management.

h. ALTERNATIVE DRUG THERAPIES _____ Discussed _____ Usefulness	0. No discussion of alternative therapies 1. Vague discussion of alternative therapies for disease. 3. Discusses alternative drug therapies for disease. 5. Explains alternative drug therapies, including assessment of usefulness for disease state.
IV. SUMMARY & PROGNOSIS: 5%	Total points for section _____ x (0.5) =
a. SUMMARY/COMPARISON TO "CLASSIC CASE" _____ Summary discussed _____ Similarities and differences to classic case _____ Includes initial hospital regimen and rationale (740 only)	0. No summary or comparison with the classic case. 1. Minimal summary provided with rare comparison to classic case. 2. Summary of patient presentation with minimal comparison to classic case. No initial in-hospital therapeutic regimen included. 3. Summary of patient presentation (740– initial in-hospital therapeutic regimen). Includes some comparison to classic case. 5. Complete summary of patient presentation (740– initial in-hospital therapeutic regimen) and rationale. Fully notes similarities and differences to classic case.
b. PROGNOSIS OF PATIENT _____ Discussed _____ Good or bad _____ Related to patient	0. No discussion of prognosis of patient presented. 3. States only that prognosis is good or poor for patient presented. 5. Discusses specific prognostic factors as related to the patient presented.
V. DISCUSSION: 5%	Total points for section _____ x (1.0) =
a. LEADERSHIP _____ No instructor input _____ Led by student _____ Answered questions appropriately	0. Was not able to answer questions. 1. Poor. Able to answer a few questions, but mainly answered by instructors. 2. Marginal. Able to answer a some questions, but mostly answered by instructors. 3. Average. Most of the questions answered by the student correctly (> 50%). 4. Very good. Instructors provided minimal answers to questions. 5. Excellent. Instructors provided almost no input answering questions.
VI. COMMUNICATION: 10%	Total points for section _____ x (1.0) =
a. VERBAL _____ Audible _____ Good enunciation _____ Appropriate rate _____ Variable tone _____ Correct pronunciation _____ Correct use of terms	1. Poor, hard to hear or understand. Mumbles and/or delivery shows lack of interest. Rate too fast or too slow. Many pronunciation errors or inappropriate use of medical terms. 2. Needs improvement in loudness and/or some words lost to mumbling. Sometimes monotone without interest in material. Many pronunciation errors or inappropriate use of medical terms. 3. Average. Adequate loudness but some words lost to mumbling. Tone and rate reflects interest in material. Some errors in pronunciation or inappropriate use of medical terms. 4. Very good. Audible with good enunciation. Tone and rate reflect interest in material. Few errors in pronunciation or inappropriate use of medical terms. 5. Excellent. Audible, good enunciation. Appropriate rate and tone to reflect interest. Easy to listen to. No errors in pronunciation and use of medical terms.
b. NON-VERBAL _____ No distractions _____ Shows polish, poise _____ Outstanding eye contact _____ Rarely relies on notes	1. Poor. Mannerisms so distracting, presentation content was lost. No eye contact. 2. Needs improvement. Mannerisms very distracting. Little eye contact. Reads all of case. 3. Average. Few distracting mannerisms. Good eye contact within presentation setting. Reads some of case. 4. Very good. No distracting mannerisms, appropriate gestures. Good eye contact within presentation setting. Paper used as a reference. 5. Excellent. No distractions. Shows polish, poise as speaker. Good eye contact within presentation setting and rarely relies on notes.

VII. HANDOUT/REFERENCES: 5%	Total points for section _____ x (0.5) =
a. HANDOUT/AUDIO-VISUAL AIDS _____ Patient presentation _____ No major omissions _____ Outline _____ No uncorrected misspellings/typos _____ Patient counseling tool _____ Asset to presentation _____ Kardex _____ Charts and diagrams referenced _____ Labs _____ Clinical monitoring notes _____ Organized, neat, readable	0. No handout. 1. Poor--incomplete, unorganized, hard to locate material, difficult to read. 2. Needs improvement--incomplete, sloppy, hard to read, many misspellings or did not utilize handout appropriately. 3. Average--complete, organized, neat and readable. Many uncorrected misspellings and/or 1 major omission. 4. Very good--complete, neat, readable and organized. 0-few corrected misspellings. Asset to presentation. 5. Excellent--complete, organized, neat and readable. No major omissions or uncorrected misspellings. Additional information provided that is an asset to presentation.
b. REFERENCES--FOLLOW GUIDELINES IN APPENDIX A _____ Comprehensive listing _____ Primary and tertiary included _____ Citation format complete/accurate	0. No literature sources appear to have been used. 1. Minimal literature sources are cited for discussion of diseases state or treatment. Incorrect literature citation format. 2. Limited literature sources are cited for discussion of both disease state and treatment. Some are inappropriate. Incorrect literature citation format. 3. Adequate citation of literature for discussion of both disease state and treatment. Most are appropriate. Some errors in citation format. 4. Very good citation of pertinent literature sources. Few errors in citation format. Minor punctuation errors. 5. Comprehensive listing of literature sources. Primary and tertiary references are used. Citation format is complete and accurate.
VIII. TIME: 5%	Total points for section _____ x (1.0) =
a. WITHIN TIME LIMITS Give 5 minute remaining warning. Stop at 30 minutes deduct 4 points in section. Grade relevant sections based upon what <u>was</u> presented.	1. Presentation with discussion < 25 minutes or > 30 minutes 5. Presentation with discussion 25-30 minutes.

Overall Comments:

Score I _____
II _____
III _____
IV _____
V _____
VI _____
VII _____
VIII _____

Total _____

Clinical Instructor Signature _____
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BACKGROUND – THE STUDY QUESTION?	
Background	• **Provide general background on the topic including why we use this therapy and what current practices are in relation to this therapy and disease state**
Previous trials	• **List Major applicable trials: including reference and citation only** • **Be prepared to provide details (PIES) of these trials**
Why this study?	• **Explain what this study will provide to clinical practice**
GENERAL STUDY OVERVIEW	
Title/Citation	•
Funding	•
Null Hypothesis	•
Trial design	•
Objectives	•
Enrollment	•
Inclusion criteria	•
Exclusion criteria	•
Interventions	•
Endpoints	•
Statistical analyses	•
Monitoring	•
Enrollment	•
Baseline characteristics	•
Primary Outcome	•
Adverse Events	•
Etc	•
	•
	•

AUTHORS' CONCLUSIONS

Brief description of the authors view and conclusion of the trial and outcomes

STOP at this point and open the floor to discussion for the following section as you step by step through the PIES method of Critically Evaluating Clinical Trials®

GENERALIZABILITY/CRITIQUE/DISCUSSION	
Patient Population	❑ Are there any major differences in patient characteristics that may confound the results ❑ Evaluate inclusion and exclusion criteria serve as a guide to the patients that the results may be applicable
Intervention	❑ Is the intervention being tested representative of current practice or derived from previous well-conducted studies
Endpoints	❑ Do the endpoints of the trial truly represent what is claimed as being studied ❑ Is the endpoint used in the trial clinically significant ❑ If a surrogate endpoint is used, is it validated for correlation to a hard clinical endpoint

Statistics	❑ What type of data is being assessed (nominal, ordinal, continuous) ❑ Are the statistical tests used to evaluate the data appropriate[1] ❑ Is the effect size clinically relevant ❑ Evaluate the results in absolute values and calculate number needed to treat (NNT) ❑ Were subgroups and/or secondary endpoints evaluated? If so what significance can we take from them?
Leader's Conclusion	

*Template message (this is to be deleted for journal club): This is to serve as a template for your journal club handout. This should not exceed one page (front and back) upon completion, as all attendees are to have read the article prior to JC.

Patient Profile Review Using the PPCP - Sample Documentation Form

Patient Demographics

Patient's Initials: _____ Gender: _____ Age: _____
Height: _____ Weight: _____
Source of History: _____

Renal Function: _____ Hepatic Function: _____

Insurance Information:

Problem list:

Drug Allergies:

Medications:

SOAP Note:

S: (Subjective information gathered from patient/caregiver)

O: (Data measured or observed directly or obtained from an original source)

A: (Conclusions about information gathered)

P: (Actions taken, actions patient must take)

Patient Profile Review Using the PPCP- Evaluation Form

Please note: This **one** form is used for all **five** patient profile reviews.

I. **Database**

0	1	2	3	4
No database described.	The database is incomplete or contains inaccurate information	All database areas are described and accurate but contain minimal information.	All database areas are described and accurate with an attempt to assess available data.	All database areas are described and accurate with full assessment of available data.
Comments:				
Scores for profile reviews #1 _____ #2 _____ #3 _____ #4 _____ #5 _____				
Step 1 – Collect subjective and objective information				

II. **Drug Related/Medical (DR/M) Problem List**

0	1	2	3	4
No drug related/medical (DR/M) problems identified on Clinical Monitoring Note (CMN).	All DR/M problems (requiring monitoring) are not accurately identified on CMN.	Most DR/M problems (requiring monitoring) are accurately identified on CMN.	All DR/M problems (requiring monitoring) are accurately identified on CMN.	A comprehensive listing of DR/M problems (requiring monitoring) are accurately identified on CMN.
Comments:				
Scores for profile reviews #1 _____ #2 _____ #3 _____ #4 _____ #5 _____				
Step 2: Assess information collected in Step 1.				

III. **Progress Notes**

0	1	2	3	4
Progress notes not done.	Progress notes do not follow the standard format. Are sloppy, hard to follow, incomplete.	Notes are readable and follow the standard format, but do not always include the necessary (SO) or (AP) data. Prospective and patient specific monitoring is not present.	Notes are complete, accurate, and organized in standard format with most (SO) and (AP) data present. Some prospective and patient specific monitoring regimen is present.	Notes are complete, accurate and organized in standard format with all (SOAP) data present. Notes comprehensively reflect prospective and patient specific monitoring.
Comments:				
Scores for profile reviews #1 _____ #2 _____ #3 _____ #4 _____ #5 _____				
Steps 3, 4, 5 Plan, Implement, and Follow Up				

Total Scores for profile reviews #1 _____ #2 _____ #3 _____ #4 _____ #5 _____

Student Signature _____

Clinical Instructor Signature _____