Patient Care: Patient Care

PGY1 - Community Pharmacy (95904)

Faculty: Patricia Lambro, Sherry Whitley

Site: Peninsula Community Health Services
Status: Required
Type/Duration: Longitudinal, 12 months
Time: 8-32 hours/week

Description:

Over the course of this 12 month learning experience, the Resident will participate in a variety of direct and indirect patient care services for disease state management and medication management.

Chronic disease state services will focus on diabetes, hypertension, immunizations, hyperlipidemia and anticoagulation management. The resident will be expected to know chronic disease state guidelines to guide care and form evidence-based care plans. During encounters, the resident may gather information from the EHR, measure pertinent vital signs, perform point of care labs, provide disease state education, make changes to the medication regimen and/or coordinate care with providers, document care in the EHR and bill for direct care visits. The resident will gain experience learning and applying the ACIP/CDC vaccine recommendations for adults, ordering and administering vaccines to patients under a clinical protocol, as well as documenting vaccine administration and billing for these services. During this experience, the resident will gradually take on responsibility for direct patient care and will be expected to develop high-quality, evidence-based medication and disease state management services individualized to each patient's needs. The resident will also participate in Peer Review of clinical work and help develop quality improvement initiatives to improve patient care.

Medication management activities include Medication Adherence monitoring and counseling, Targeted Medication Reviews (TMRs), Medication Therapy Managements (MTMs), Comprehensive Medication Reviews (CMRs) and Transitions of Care (TOC) activities. The Resident will gain experience using the Outcomes platform as well as documenting interventions in the Electronic Health Record (EHR). The resident will be responsible for at least one project associated with medication-related quality measures for PCHS.

Preceptors and Resident will choose a vaccine or population to focus outreach efforts on depending on the needs of our patient population and vaccine supplies, making sure to include at least 3 of the following vaccine types: Influenza, Tetanus, Tdap, Varicella, HPV, Zoster, MMR, Pneumococcal, Hepatitis A and Hepatitis B. Resident should complete a targeted vaccine outreach for a specified patient sub-population or vaccine type.

The Residency Program Director (RPD) will determine when the resident is proficient as an independent pharmacist. Proficiency is determined based on direct observation by the preceptors and RPD that the resident conducts themselves in an appropriate and professional manner, can make sound evidence-based care plans, document and bill all encounters accurately in the EHR.

Role of Pharmacists:

Pharmacists at PCHS serve as key members of the interdisciplinary patient care team, collaborating to provide comprehensive medication management services for chronic disease states within the primary care setting. We work under protocols and collaborative practice agreements to offer immunization,

anticoagulation, diabetes, hypertension and smoking cessation management services. We also perform CMRs and MTMs, medication adherence monitoring, Transition of Care services, and participate in many organizational medication-safety and medication-related quality initiatives.

Expectation and Progression of Resident:

Quarter 1: July-September

- Resident will review all major chronic disease state guidelines (diabetes, hypertension, hyperlipidemia, CHF, ASCVD prevention, anticoagulation) and have focused discussions with preceptors
- Resident will review PCHS Clinical protocols and collaborative drug therapy agreements (CDTAs) regarding medication management and chronic disease state management
- Resident will complete CLIA test competencies for INR and A1c machines
- Resident will sign CDTA with PCHS CMO and submit to WA DOH
- Resident will discuss how JCPP Patient Care Process applies to patient care visits and present a patient case using this principal
- Resident should seek certification in Anticoagulation and Diabetes Management through an approved program.
- Resident should complete immunization certificate if not already done
- Resident should be able to demonstrate understanding of CDC adult vaccine recommendations and apply them to patient profiles to determine which immunizations are needed.
- Resident should demonstrate correct reconstitution, preparation, administration, and billing of vaccines under preceptor supervision.
- Resident should be able to independently complete administration and documentation of services in patient record and process billing of services if applicable.
- Resident will begin working through clinical competency checklist with preceptors and complete Anticoagulation assignments
- Resident will begin by shadowing clinical pharmacist for chronic disease management visits and become familiar with EHR documentation and billing rules.

Quarter 2-3: October-March

- Resident will begin participating in development of evidence-based care plans and work towards performing patient care visits independently
- Resident will register for Outcomes account and complete training modules for MTMs and CMRs
- Resident will shadow preceptor for MTM and CMR visits, help with data collection and patient care plan
- Resident will also be introduced to medication-related quality measures and complete a minimum of 1 TMR project
- Resident will work medication adherence reports, counsel patients on opportunities for medication adherence improvement, then identify and perform any MTMs or CMRs for eligible patients
- Resident will review Transitions of Care protocol, discuss how PCHS pharmacists perform these tasks, and shadow preceptors in this work
- Resident will begin completing TOC tasks and documentation with preceptor oversight
- Resident will help precept an IPPE or APPE student if present.

Quarter 4: April-June

- Resident should be able to independently perform clinical care visits, including completion of documentation and billing for the visit.
- Resident should be able to compete CMR, MTM and TOC encounters independently with follow up plans and thorough documentation.
- Resident will participate in Peer Review of pharmacist work
- Resident will develop CQI plan for one patient care disease state
- Resident will help precept an IPPE or APPE student for ambulatory care services if present.

*The length of time spent in each phase of learning will depend on the resident's progression.

Required goals and objectives for Patient Care longitudinal rotation:

GOAL DESCRIPTION		OBJECTIVE DESCRIPTION		ACTIVITY
R1.1	Provide safe and effective patient care services including medication management, health and wellness, immunization, and disease state management including medication management following the JCPP Pharmacists' Patient Care Process.3 Services are provided to a diverse range of patients in collaboration with the health care team.	R1.1.1	(Responding and Applying) Demonstrate responsibility and professional behaviors as a member of the health care team.	• Demonstrate ability to stay current with clinical literature through discussions with preceptors • Use the JCPP Pharmacist Patient Care process to identify and create action plans for medication-related problems • Show ownership of patient care outcomes by following medication-related problems to resolution • Apply immunization guidelines to patient profiles to identify opportunities for immunization updates
		R1.1.2	(Responding and Applying) Establish a patient-centered relationship with the individual patient, family members, and/or caregivers.	• Show empathy and respect for patient, family and caregivers during patient care appointments • Produce individualized patient care plans via engagement of patient, family and caregivers (when appropriate) • Demonstrate ability to create longitudinal patient relationships over the course of chronic disease management visits
		R1.1.3	(Valuing and Analyzing) Collect relevant subjective and objective information for the provision of individualized patient care.	• Identify, access and reference appropriate sources of information for each task/project • Apply a systematic method for collecting information • Select subjective and objective information relevant to the provision of care • Order, perform, and evaluate laboratory tests as necessary for chronic disease or medication management
		R1.1.4	(Analyzing) Analyze and ***assess information collected and prioritize problems*** for provision of individualized patient care.	• Analyze the information in relation to patient's overall health goals and optimal care (ex: medication indication/adherence/side effects) • Identify unmet preventative care needs for patient • Identify medication therapy problems or gaps • Prioritize problems based on clinical importance as well as patient values/preferences
		R1.1.5	(Valuing and Creating) Design a ***safe and effective individualized patient-centered care plan*** in collaboration with other health care professionals, the patient, and caregivers.	• Design individualized patient-centered care plans • Justify clinical recommendations using current clinical guidelines • Construct SMART goals in collaboration with patient, family and care givers (if appropriate)

				• Develop plans for care continuity including implementation of care plan, follow up, and collaborating with other healthcare professionals
		R1.1.6	(Applying) ***Implement*** the care plan in collaboration with other health care professionals, the patient, and caregivers.	• Initiate, modify, or administer medications or vaccines according to care plan, as allowed by protocol or CDTA • Work with patients to modify self-management goals over time, during disease state management visits • Predict which medication related problems will require coordination of care and help patient schedule follow up with appropriate care providers
		R1.1.7	(Evaluating) ***Monitor and evaluate*** the effectiveness of the care plan and ***modify the plan*** in collaboration with other health care professionals, the patient, and caregivers as required.	• Evaluate patient progress with care plan over longitudinal care visits • Compare clinical endpoints against standards of care • Recommend appropriate schedule for follow up or referral for further care to achieve goals of care plan
		R1.1.8	(Valuing and Applying) ***Collaborate and communicate*** effectively with **patients, family members**, and caregivers	• Use clear concise language at the appropriate literacy level • Use open ended questions and the teach back method to verify patient understanding
		R1.1.9	(Valuing and Applying) **Collaborate and communicate** effectively with other **health care team members**.	• Use clear concise language when making recommendations to the clinical care team • Justify clinical recommendations with evidence-based literature • Establish relationship with provider team in which trust is demonstrated by progression of delegated responsibility
		R1.1.10	(Applying) Document patient care activities appropriately and efficiently.	• Produce clear, concise, neatly formatted patient care notes within 24 hours of visit, free of typos or inappropriate abbreviations • Employ standardized Outcomes workflow to complete CMR documentation in the Outcomes platform and/or EHR
R1.3	Provide safe and effective medication-related patient care when patients transition between care settings	R1.3.1	(Analyzing) ***Identify needs*** of individual patients experiencing care transitions.	• Identify patients receiving care from multiple providers or pharmacies and perform medication reconciliation when needed • Identify medication-related problems using the JCPP PPCP • Prioritize medication-related problems in order of clinical urgency and patient preference

		R1.3.2	(Applying) Manage and facilitate care transitions between patient care settings.	• Apply JCPP PPCP and Transition of Care workflows to resolve medication-related problems • Prepare a plan to communicate accurate and timely follow up for patients transferring care to another facility or pharmacy • Employ resources to make care connections as needed (home health, transportation, specialist care, BH) • Document services provided, actions taken, and outcomes achieved as applicable
R4.2	Effectively employ appropriate preceptor skills when engaged in experiential teaching (e.g., students, pharmacy technicians, or other health care professionals)	R4.2.1	(Analyzing) Identify experiential learning activities and select appropriate preceptor roles to meet learners' educational needs	• Identify experiential learning opportunities for WIP, IPPE or APPE students by reviewing the manuals for each learning experience type • Apply the 4 preceptor roles (instructing, modeling, coaching, and facilitating) to facilitate learning during patient care appointments • Select appropriate problem-solving situations for independent work by the learner
		R4.2.2	(Analyzing) **Provide** appropriate and timely **formative and summative feedback** and ensure learner **understands the feedback** during experiential learning	• Identify appropriate timing to give feedback to the learner • Differentiate between formative and summative feedback, and which is appropriate based on activity • Select a student project and produce written formative feedback for the learner • Produce a written summative evaluation for a learner

Evaluation:

Formative evaluation and feedback will be provided throughout the project development process.
Summative evaluations will be conducted quarterly with the resident and preceptor independently completing PharmAcademic evaluations.

	Evaluator	Evaluated	Timing
ASHP Learning Experience Evaluation	Resident	Learning Experience	Ending and quarterly if needed
ASHP Preceptor Evaluation	Resident	All preceptors of this Learning Experience	Ending and quarterly if needed
Summative Evaluation	Resident	Each resident taking this Learning Experience	Ending and quarterly if needed
Summative Evaluation	All Preceptors	Each resident taking this Learning Experience	Ending and quarterly if needed

Elements for portfolio and PharmAcademic:

- Diabetes management, anticoagulation management and immunization provider certificates
- Anticoagulation questions

- Clinical competency checklist
- JCPP PPCP patient case worksheets
- 5 de-identified examples of patient care notes for Medication Management services (CMR, TMR, MTM)
- 5 de-identified examples of patient care notes for Disease State Management including the following disease states: diabetes, hypertension, hyperlipidemia, CHF, mental health, respiratory disease
- 5 de-identified examples of patient care notes for Care Transitions
- 5 de-identified examples of patient care notes for immunizations
- 5 examples of communications relaying medication-related problems to medical providers
- Written documentation of formative and/or summative feedback given to learner (if applicable)