2018-2019
PGY1 COMMUNITY-BASED PHARMACY RESIDENCY HANDBOOK
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Additional policies available at [https://sites.google.com/site/stlcopresidency/](https://sites.google.com/site/stlcopresidency/).
PGY1 Community-Based Pharmacy Residency Program Purpose
To build upon the doctor of pharmacy (PharmD) education and outcomes to
develop community-based pharmacist practitioners with diverse patient care,
leadership, and education skills who are eligible to pursue advanced training
opportunities including postgraduate year two (PGY2) residencies and
professional certifications.

Additionally, the St. Louis College of Pharmacy Community-Based Pharmacy
Residency Program prepares community practitioners to provide, advance, and
assess patient care services in community practice and to teach in both
didactic and experiential environments.

STLCOP MISSION, VISION AND VALUES

Mission
St. Louis College of Pharmacy provides an inclusive, supportive and enriching environment
for growth, learning and leadership to prepare our students, residents, faculty, staff and
alumni to positively impact patients and society.

Vision
St. Louis College of Pharmacy will be a globally prominent leader in pharmacy and health
care education, interprofessional, patient-centered care and collaborative research.

Values
- Diversity
- Growth
- Inclusion
- Integrity
- Positivity
- Professionalism
- Respect
Residency Standards & Competency Areas, Goals, and Objectives for PGY1 Community-Based Pharmacy Residencies

Insert a copy of the ASHP/APhA PGY1 Community-Based Pharmacy Residency Standards and Goals & Objectives. (2 files)

Residents should read and be familiar with both of these documents.
Accreditation Standard for Postgraduate Year One (PGY1) Community-Based Pharmacy Residency Programs

Prepared jointly by the American Society of Health-System Pharmacists (ASHP) and the American Pharmacists Association (APhA)

Purpose of this Standard: The Accreditation Standard for Postgraduate Year One (PGY1) Community-Based Pharmacy Residency Programs (hereinafter the Standard) establishes criteria for systematic training of pharmacists for the purpose of achieving professional competence in the delivery of patient-centered care and in pharmacy services. Its contents delineate the requirements for American Society of Health-System Pharmacists (ASHP)-accreditation of PGY1 community-based pharmacy residencies. A PGY1 pharmacy residency is a prerequisite for postgraduate year two (PGY2) pharmacy residencies.

PGY1 Community-Based Pharmacy Residency Program Purpose: to build upon the doctor of pharmacy (PharmD) education and outcomes to develop community-based pharmacist practitioners with diverse patient care, leadership, and education skills who are eligible to pursue advanced training opportunities including postgraduate year two (PGY2) residencies and professional certifications.

Pharmacist residency education and training in community-based practice aims to develop pharmacy leaders who are capable of improving the health of patients within the communities they serve. The primary purpose of this Standard is to foster the development of community-based pharmacist practitioners¹ who are community-focused practice leaders, serving as an access point for care and having the skillset necessary to provide quality generalist patient care services² wherever health and medication needs arise.

Application of the Standard: The requirements serve as the basis for evaluating a PGY1 community-based pharmacy residency program for accreditation. It is recognized that in the application of this Standard, training locations may vary and diverse community-based practices³ may find utility in the use of this Standard. Additionally, because of the diversity of patient populations, service offerings, and


² Generalist patient care services include but are not limited to medication management including the provision of comprehensive medication reviews and follow-up; health and wellness services; immunization services; disease state management services incorporating medication management; care transition services with incorporated medication reconciliation and medication management; and patient-centered medication distribution.

³ A variety of community-based practices may find utility in the use of this Standard including but not limited to community pharmacies, ambulatory care clinics, physician offices, free clinics, federally qualified health centers, employer-based clinics, assisted-living facilities, hospice, home care, and adult/pediatric hospitals with outpatient pharmacies/clinics.
business models, it is recognized that individual practice locations\(^4\) may be unable to provide all of the Standard’s requirements for diversity, variety, and complexity; however, it is intended that the combination of all practice locations used for the training of the individual resident meets the requirements as set forth by the Standard and that each resident has a designated community-based home-base\(^5\) practice location.

Throughout the Standard use of the auxiliary verbs *will* and *must* implies an absolute requirement, whereas use of *should* and *may* denotes a recommended guideline.

Accreditation of pharmacy residency programs is conducted under the authority of the ASHP Board of Directors and for this Standard is supported through a formal partnership with the American Pharmacists Association (APhA). The *ASHP Regulations on Accreditation of Pharmacy Residencies* sets forth the policies governing the accreditation program and describes the procedures for seeking accreditation.

**Overview of the Standards for PGY1 Community-based Pharmacy Residencies**
The following explains the rationale and importance of the areas selected for inclusion in the standards.

**Standard 1: Requirements for Resident Selection and Resident Completion of the Program**
This Standard is intended to help ensure success of residents and that exemplary pharmacists are identified for further development for the benefit of the profession and contributions to patient care. Therefore, residents must be pharmacists committed to attaining professional competence beyond entry-level practice, committed to attaining the program’s educational goals and objectives, and supportive of the organization’s mission and values.

**Standard 2: Responsibilities of the Program to the Resident**
It is important that pharmacy residency programs provide an exemplary environment for residents’ learning. This area indicates policies that must be in place to help protect residents and organizations during unusual situations that may arise with residency programs (e.g. extended leaves, dismissal, duty hours).

**Standard 3: Design and Conduct of the Residency Program**
It is important that residents’ training enables them to achieve the purpose, goals, and objectives of the residency program and become more mature, clinically competent practitioners, enabling them to address patients’ needs. Proper design and implementation of programs helps ensure successful residency programs.

**Standard 4: Requirements of the Residency Program Director and Preceptors**
The residency program director (RPD) and preceptors are critical to the residency program’s success and effectiveness. Their qualifications and skills are crucial. Therefore, the residency program director and

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\(^4\) Community-based residency practice location is a place where preceptors are training residents. A practice location may consist of one or more places where residents can be trained within a single organization (i.e., a pharmacy chain, a college of pharmacy with clinic pharmacies, a health-system with outpatient/clinic pharmacies).

\(^5\) Home-base practice location is the place designated as a resident’s primary practice site for residency training.
preceptors will be professionally and educationally qualified pharmacists who are committed to providing effective training of residents and being exemplary role models for residents.

Standard 5: Requirements for Organizational Structure of the Residency Program
It is important that residents learn to help institute best practices in their future roles; therefore, the organization conducting the residency must meet accreditation standards, regulatory requirements, and other nationally applicable standards, and will have sufficient resources to achieve the purposes of the residency program.

Standard 6: Pharmacy Practice
When pharmacy facilities and services provide the learning environment where residents are trained, it is important that they train in exemplary environments. Residents’ expectations as they leave residency programs should be to strive for exemplary pharmacy services to improve patient care outcomes. Pharmacy’s role in providing effective leadership, quality improvement efforts, appropriate organization, staffing, automation, and collaboration with others to provide safe and effective medication-use systems are reviewed in this section. This section encourages sites to continue to improve and advance pharmacy services and should motivate the profession to continually improve patient care outcomes.
Standard 1: Requirements for Resident Selection and Resident Completion of the Program

1.1 The residency program director (RPD) or designee evaluates the qualifications of applicants to pharmacy residencies through a documented, formal procedure based on predetermined criteria.

1.2 The predetermined criteria and procedure used to evaluate applicants’ qualifications are used by all involved in the evaluation and ranking of applicants.

1.3 Applicants to pharmacy residencies are graduates or candidates for graduation of an Accreditation Council for Pharmacy Education (ACPE)–accredited degree program (or one in process of pursuing accreditation) or have a Foreign Pharmacy Graduate Examination Committee (FPGEC) certificate from the National Association of Boards of Pharmacy (NABP).

1.4 Applicants to pharmacy residencies are licensed or eligible for licensure in the state or jurisdiction in which the program is conducted.

1.5 Consequences of residents’ failure to obtain appropriate licensure either prior to or within ninety days of the start date of the residency are addressed in written policy of the residency program.

1.6 Program policies, requirements for successful completion of the program, and expectations of residents in the program are documented.
   1.6.a Program policies, requirements for successful completion of the program, and expectations of residents in the program are provided (either in print or electronically) to interviewees prior to the interview date. Applicants are given the opportunity to obtain more information and ask questions during the interview process.

Standard 2: Responsibilities of the Program to the Resident

2.1 Programs is a minimum of twelve months and a full-time practice commitment or equivalent.
   2.1.a Nontraditional residency programs describe the program’s design and length used to meet the required educational competency areas, goals, and objectives.

2.2 Programs must comply with the ASHP duty-hour standards.

2.3 All programs in the ASHP accreditation process adhere to the Rules for the ASHP Pharmacy Resident Matching Program, unless exempted by the ASHP Commission on Credentialing.

2.4 The RPD provides residents who are accepted into the program with a letter outlining their acceptance to the program.
   2.4.a Information on the pre-employment requirements for their organization (e.g., licensure and human resources requirements, such as drug testing and criminal record check) and other relevant information (e.g., benefits, stipend) must be provided.
2.4.b Acceptance by residents of the residency terms and conditions, requirements for successful completion, and expectations of residents in the program are documented prior to the beginning of the residency.

2.5 The residency program provides qualified preceptors to ensure appropriate training, supervision, and guidance to all residents to fulfill the requirements of the standards.

2.6 The residency program provides residents with an area in which to work, access to references, an appropriate level of relevant technology, access to educational opportunities, and sufficient financial support to fulfill the responsibilities of the program.

2.7 The RPD documents residents’ successful completion of program requirements.

2.8 The RPD issues a certificate only to residents who complete the program’s requirements in accordance with the provisions of the ASHP Regulations on Accreditation of Pharmacy Residencies.

2.8.a The certificate is signed by the RPD and the chief executive officer of the organization or an appropriate executive with ultimate authority over the residency.

2.8.b When the program has achieved accreditation, appropriate reference is made on the certificate of the residency that the program is accredited by ASHP in partnership with APhA.

2.9 The RPD maintains the program’s compliance with the provisions of the current version of the ASHP Regulations on Accreditation of Pharmacy Residencies throughout the accreditation cycle.

Standard 3: Design and Conduct of the Residency Program

3.1 Residency Purpose and Description. The residency program is designed and conducted in a manner that supports residents in achieving the following purpose and the required educational competency areas, goals, and objectives described in the remainder of the standards.

3.1.a PGY1 Community-Based Pharmacy Residency Program Purpose. To build upon the doctor of pharmacy (PharmD) education and outcomes to develop community-based pharmacist practitioners with diverse patient care, leadership, and education skills who are eligible to pursue advanced training opportunities including postgraduate year two (PGY2) residencies and professional certifications.

3.1.b Individualized Program Description. Each PGY1 community-based pharmacy residency program establishes, documents, and promotes a brief description of its program that aligns with the universal purpose statement of a PGY1 community-based pharmacy residency program and elaborates on the unique aspects of its program.

3.2 Competency Areas, Educational Goals, and Objectives

3.2.a The program’s educational goals and objectives support achievement of the residency’s purpose.
3.2.b The following competency areas and all associated educational goals and objectives are required by the Standard and must be included in the program’s design:

3.2.b.1 patient care.
3.2.b.2 leadership and management.
3.2.b.3 advancement of community-based practice and improving patient care.
3.2.b.4 teaching, education, and dissemination of knowledge.

3.2.c Beyond those required in 3.2b, additional educational goals and/or objectives may be included in the program design under required competencies that then become required for all residents in the program.

3.2.d For a specific resident, additional educational goals and/or objectives may be added to customize his or her individual training.

3.3 Program Structure and Design

3.3.a The structure of the program is established, described, and formally documented.

3.3.a.1 The description includes a list of all required and elective learning experiences.

3.3.a.2 The description includes the type (e.g., longitudinal, rotational, extended, concentrated) of each learning experience.

3.3.a.3 The description includes the duration for each learning experience.

3.3.b The program’s structure facilitates achievement of the program’s educational goals and objectives.

3.3.c The program’s structure and design facilitate education and training of the resident in patient care (can be accomplished using one or more practice locations) including:

3.3.c.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;
3.3.c.2 health and wellness;
3.3.c.3 immunizations;
3.3.c.4 disease state management incorporating medication management;
3.3.c.5 care transitions incorporating medication reconciliation and medication management; and,
3.3.c.6 patient-centered medication distribution.

3.3.d The structure permits residents to gain experience and sufficient practice with diverse patient populations with a variety of disease states and conditions, and diverse range of patients’ medication treatments and health-related needs.

3.3.d.1 Residents spend two-thirds or more of the program in patient care activities.
3.3.d.2 Residents spend no more than one-third of the twelve-month PGY1 pharmacy residency program in a practice or environment providing care to a specific patient disease state and population (e.g., monitoring and management of anticoagulation, oncology, HIV, and hepatitis C patients).
3.3.d.3 Residents gain practice and experience in longitudinal patient care delivery and the development of extended patient relationships.
3.3.d.4 Residents function and work as a member of the health care team.
3.3.d.5  Residents provide patient care in settings and environments with and without access to existing sources of complete patient health data.

3.3.d.6  Residents appropriately document patient care in the patient’s health care record.

3.3.d.7  Residents use technology including electronic health record functionality.

3.3.d.8  Residents progress over the course of the residency to become more efficient and effective with the ability to work independently as patient care providers.

3.3.e  Learning Experience Requirements

3.3.e.1  Learning experience descriptions are documented and include:

3.3.e.1.1  a general learning description synopsis, that includes the practice area and the roles of pharmacists in the practice area;

3.3.e.1.2  expectations of residents;

3.3.e.1.3  educational goals and objectives assigned to the learning experience;

3.3.e.1.4  for each objective, a list of learning activities that will facilitate its achievement; and,

3.3.e.1.5  a description of evaluations that are to be completed by preceptors and residents.

3.3.e.2  Program structure includes a residency program orientation learning experience where the RPD or designee orients residents to the residency program.

3.3.e.2.1  For all other learning experiences, preceptors orient residents to their learning experience, including review of the learning experience description.

3.3.e.2.2  The learning experience design requires preceptors to use the four preceptor roles (i.e., instructing, modeling, coaching, facilitating).

3.4  Assessment and Evaluation Requirements

3.4.a  RPD and Preceptor Evaluation Requirements

3.4.a.1  Initial Evaluation

3.4.a.1.1  At the beginning of the residency, the RPD or designee, in conjunction with preceptors, assesses each resident’s entering knowledge and skills in relation to the educational goals and objectives.

3.4.a.2  Formative (Ongoing, Regular) Evaluation

3.4.a.2.1  Preceptors provide ongoing, frequent, immediate, specific, and constructive feedback to residents about how they are progressing and how they can improve.

3.4.a.2.2  Preceptors make appropriate adjustments to residents’ learning activities in response to information obtained through day-to-day observations, interactions, and assessments.

3.4.a.3  Summative Evaluation
3.4.a.3.1 At the end of each learning experience, preceptors for the learning experience complete and document a criteria-based, summative evaluation of the resident’s progress toward achievement of educational goals and objectives assigned to the learning experience.

3.4.a.3.1.1 If more than one preceptor is assigned to a learning experience, all preceptors provide input into the resident’s evaluation.

3.4.a.3.1.2 For longitudinal learning experiences greater than twelve weeks but less than six months in length, a documented summative evaluation is completed at least twice, at the midpoint and end of the experience. For those greater than six months, summative evaluations are conducted quarterly (every three months) and at the conclusion of the learning experience.

3.4.a.3.2 The preceptor and resident discuss the summative evaluation and the extent of the resident’s progress toward achievement of assigned educational goals and objectives with reference to specific criteria.

3.4.a.3.3 Completed summative evaluations are signed by learning experience preceptors, cosigned by the resident, and reviewed by the RPD or designee.

3.4.a.3.3.1 For preceptors-in-training, both the preceptor-in-training, and the preceptor advisor/coach sign evaluations.

3.4.b Development Plan Requirements

3.4.b.1 The RPD or designee creates, documents, and maintains a development plan for each resident.

3.4.b.1.1 The RPD or designee creates an initial development plan.

3.4.b.1.1.1 The initial plan is based on the results of the resident’s initial self-evaluation.

3.4.b.1.1.2 The initial plan is completed by the end of the orientation period, but no later than thirty days from the start of the residency.

3.4.b.1.1.3 Adjustments to the resident’s learning experiences, learning activities, evaluations, and other changes are documented in the initial plan.

3.4.b.2 Quarterly Update of Development Plan

3.4.b.2.1 On a quarterly basis, the RPD or designee assesses the resident’s progress and adjusts the development plan.

3.4.b.3 The development plan and any adjustments are documented and shared with the resident’s preceptors.
3.4.c  Resident Evaluation Requirements

3.4.c.1  Self-Reflections
3.4.c.1.1  Residents complete a written statement of self-reflection at the beginning of the residency to identify learning expectations and desired areas of professional growth.
3.4.c.1.2  Residents complete a written statement of self-reflection at the conclusion of residency to identify competencies achieved, competencies requiring additional attention, and a plan for future professional development.

3.4.c.2  Initial Self-Evaluation
3.4.c.2.1  Residents complete a self-evaluation of their entering knowledge and skills related to the educational goals and objectives.

3.4.c.3  Formative (Ongoing, Regular) Self-Evaluation
3.4.c.3.1  Residents practice criteria-based, formative self-evaluation for aspects of their routine performance.

3.4.c.4  Summative Self-Evaluation
3.4.c.4.1  The program has a defined plan for the resident to complete and document criteria-based, summative self-evaluation toward achievement of targeted objectives in learning experiences.
3.4.c.4.2  Residents are taught how to perform self-evaluation.

3.4.c.5  Resident Evaluation of Preceptor
3.4.c.5.1  Residents complete at least one evaluation of each preceptor assigned to a learning experience.
3.4.c.5.2  For longitudinal learning experiences greater than twelve weeks in length, preceptor evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.
3.4.c.5.3  If one preceptor is assigned to more than one longitudinal learning experience, the resident may complete only one combined evaluation for the individual preceptor.
3.4.c.5.4  The preceptor and resident discuss the resident’s preceptor evaluation.
3.4.c.5.5  Completed preceptor evaluations are signed by the preceptors and reviewed and cosigned by the RPD or designee.

3.4.c.6  Learning Experience Evaluations
3.4.c.6.1  Residents complete an evaluation of each learning experience at the end of the learning experience.
3.4.c.6.2  For longitudinal learning experiences greater than twelve weeks in length, learning experience evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.
3.4.c.6.3  The preceptor(s) and resident discuss the learning experience evaluation.
3.4.c.6.4 Completed learning experience evaluations are signed by the preceptor(s) and reviewed and cosigned by the RPD or designee.

3.5 Continuous Residency Program Improvement

3.5.a The RPD and the Residency Advisory Committee (RAC) (and partner representatives if applicable), engage in an ongoing process of assessment of the residency program including a formal annual program evaluation.

3.5.b The RPD or designee develops and implements program improvement activities to respond to the results of the assessment of the residency program.

3.5.c The residency program’s continuous quality improvement process must evaluate whether residents fulfill the purpose of a PGY1 community-based pharmacy residency through graduate tracking, an annual review of the program design, and a review of input from each year’s graduates.

3.5.d Information tracked must include initial employment and may include changes in employment, board certification, surveys of past graduates, or other applicable information.

Standard 4: Requirements of the Residency Program Director and Preceptors

4.1 Program Leadership Requirements

4.1.a Each residency program has a single RPD who is a pharmacist from a practice location involved in the program or from the sponsoring organization.

4.1.a.1 The RPD establishes and chairs the RAC specific to that program.

4.1.a.2 The RPD may delegate, with oversight, to one or more individuals the administrative duties/activities for the conduct of the residency program.

4.1.b Each residency program has a designated sponsoring organization.

4.1.b.1 For residencies conducted by one organization, that organization is the designated sponsoring organization.

4.1.b.2 When a residency is conducted by more than one organization (two organizations in partnership, such as a college of pharmacy, company, or health system), the partners will agree to and designate the sponsoring organization in a formal agreement.

4.1.b.2.1 The agreement includes definition of:

4.1.b.2.1.1 responsibilities of all partners;

4.1.b.2.1.2 responsibilities of the RPD; and,

4.1.b.2.1.3 the RPD’s accountability to the organizations.

4.2 Residency Program Directors (RPD)

4.2.a Eligibility of the RPD

An RPD is a licensed pharmacist who:

• has completed an ASHP-accredited PGY1 residency and a minimum of three years of pharmacy practice experience in a community or ambulatory practice environment; or,
• has completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience in a community or ambulatory practice environment; or,
• has not completed an ASHP-accredited residency, but has five or more years of pharmacy practice experience in a community or ambulatory practice environment.

4.2. Qualifications of the RPD
RPDs serve as role models for pharmacy practice, as evidenced by:
4.2.b.1 leadership within the pharmacy department or within the organization through a documented record of improvements in and contributions to pharmacy practice;
4.2.b.2 demonstration of ongoing professionalism and contribution to the profession; and,
4.2.b.3 participation in workgroups or committees within the organization.

4.2.c Leadership Responsibilities of the RPD
RPDs serve as designated and authorized leaders of the residency program and have responsibility for:
4.2.c.1 organization and leadership of the RAC that provides guidance for residency program conduct and related issues;
4.2.c.2 oversight of the progression of residents within the program and documentation of completed requirements;
4.2.c.3 appointment of preceptors for the program;
4.2.c.3.1 RPDs, in cooperation with site coordinators and partnering organization when applicable, identify preceptors for the program.
4.2.c.3.2 RPDs develop and apply criteria consistent with those required by the Standard to qualify preceptors for the program.
4.2.c.3.3 RPDs appoint preceptors once qualified.
4.2.c.3.4 RPDs or designees create and implement an overall preceptor development program and oversee the creation of individual preceptor development plans.
4.2.c.4 leadership of continuous residency program improvement in conjunction with the RAC; and,
4.2.c.5 collaboration with all partners of the program.

4.3 Pharmacist Preceptors
4.3.a Eligibility of Preceptors
A pharmacist preceptor is a licensed pharmacist who:
• has completed an ASHP-accredited PGY1 residency and a minimum of one year of pharmacy practice experience in a community or ambulatory practice environment; or,
• has completed ASHP-accredited PGY1 and PGY2 residencies with six months of pharmacy practice experience in a community or ambulatory practice environment; or,
4.3.b Qualifications of Preceptors

Preceptors demonstrate the ability to precept residents’ learning experiences as evidenced by:

4.3.b.1 ability to use preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at the level required by residents;

4.3.b.2 ability to assess and provide appropriate feedback on the residents’ performance;

4.3.b.3 recognition in the area of pharmacy practice for which they serve as preceptors;

4.3.b.4 an established, active practice in the area for which they serve as preceptor;

4.3.b.5 maintenance of continuity of practice during the time of residents’ learning experiences; and,

4.3.b.6 ongoing professionalism, including a personal commitment to advancing the profession.

4.3.c Preceptors’ Responsibilities

Preceptors serve as role models for learning experiences and they:

4.3.c.1 contribute to the success of residents and the program;

4.3.c.2 create, implement, and maintain learning experiences in accordance with Standard 3;

4.3.c.3 participate actively in the residency program’s continuous quality improvement processes;

4.3.c.4 demonstrate practice expertise, strive to continuously improve, and instruct the resident in learning experiences using established preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at appropriate levels required by the individual resident;

4.3.c.5 adhere to residency program and department policies pertaining to residents and services; and,

4.3.c.6 demonstrate commitment to advancing the residency program and pharmacy services.

4.3.d Preceptors-in-Training

4.3.d.1 Pharmacists who do not fully meet the qualifications for residency preceptors in sections 4.3.a, 4.3.b, and 4.3.c above are designated as preceptors-in-training.

4.3.d.1.1 Each is assigned an advisor or coach who is a qualified preceptor.

4.3.d.1.2 Each has a documented preceptor development plan to achieve qualifications to become a residency preceptor within two years.

4.4 Non-Pharmacist Preceptors

4.4.a When non-pharmacists (e.g., physicians, physician assistants, certified nurse practitioners, administrators) are utilized as preceptors, the RPD and preceptors determine if the resident demonstrates independence as a practitioner to participate in the learning experience.
4.4.a.1 If independence as a pharmacist practitioner is required for the resident during the learning experience, the learning experience is scheduled after the RPD and preceptors agree that the resident is adequately prepared to perform at the required level.

4.4.a.2 If the learning experience is related to inter-professional training (e.g., acquiring skills and abilities to be taught by other health care professionals such as physical assessment and triage, or if working with individuals with expertise outside patient care), RPD and preceptors determine appropriate scheduling of learning experiences to maximize education and training of the resident.

4.4.a.3 The RPD, designee, or other pharmacist preceptors work closely with the non-pharmacist preceptor to select the educational goals and objectives for the learning experience.

4.4.a.4 At the end of each learning experience, non-pharmacist preceptors for the learning experience complete and document a criteria-based, summative evaluation of the resident’s progress toward achievement of educational goals and objectives assigned to the learning experience.

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**Standard 5: Requirements for Organizational Structure of the Residency Program**

5.1 Requirements for a Sponsoring Organization

5.1.a All residency programs must have a sponsoring organization.

5.1.b The sponsoring organization maintains authority and responsibility for the quality of the residency program.

5.1.c The sponsoring organization ensures that the residency program meets residency accreditation requirements.

5.1.d Sponsoring organizations and all partnering organizations have signed agreement(s) that clearly define the responsibilities for all aspects of the residency program.

5.1.d.1 A method of evaluation is in place to ensure that the purpose of the residency and the terms of the agreement are being met.

5.1.d.2 A mechanism is established and documented for achieving consensus among partners on the evaluation and ranking of applicants for the residency.

5.2 Requirements for Practice Locations

5.2.a Practice locations compare the quality, safety, and financial viability of the patient care services provided at the location against national professional guidelines and Board of Pharmacy requirements to determine areas for improvement.

5.2.b Practice locations have sought and accepted outside appraisal of facilities and patient care practices, when such appraisals are established and recognized. The external appraisal is conducted by a recognized organization appropriate to the individual practice.

5.2.c Practice locations are staffed with personnel who are committed to seek excellence in patient care as evidenced by substantial compliance with professionally developed and nationally applied practice and organizational guidelines and standards, and are provided with sufficient resources to adequately conduct the program.
5.3 Requirements for Program’s Organizational Structure

5.3.a Programs are structured as either a single-site or a multiple-site program.

5.3.a.1 A PGY1 community-based single-site pharmacy residency is a program that is structured so that training occurs within one organizational entity.

5.3.a.1.1 All requirements for residency training are achievable within the individual organizational entity practice locations.

5.3.a.2 A PGY1 community-based multiple-site pharmacy residency is one in which two or more practice sites, or a sponsoring organization working in cooperation with one or more practice sites (e.g., college of pharmacy, health system) offer a pharmacy residency. A college of pharmacy (COP) is considered a practice location only if the COP has practice locations serving as a home base. 5.3.a.2.1 For multiple-site programs, a site coordinator is appointed to manage and oversee the day-to-day operations of the residency program at each home-base practice location by the RPD in cooperation with the practice location and partnering organization.

5.3.a.2.2 RPD, site coordinators, and the partnering organization, when applicable, work together to appoint and develop pharmacy staff to become preceptors for the program.

5.3.a.2.3 A mechanism is documented for achieving consensus between partners on the evaluation and ranking of applicants for the residency.

5.3.a.2.4 Multiple-site residency programs are in compliance with the ASHP Accreditation Policy for Multiple-Site Residency Programs.

5.3.a.3 Each resident in the program is assigned a specific community-based home-base practice location (site) where he or she spends no less than 40% of his or her time.

5.3.a.4 Home-base practice location (site) meets the patient care services criteria under Standard 6.

5.3.b Multiple residents may be located within a single home-base practice location if the level of services and patient care services are sufficient in diversity, variety, complexity, and quantity to educate and train multiple residents within the practice.

5.3.c Program is structured as a Single or Multiple Training Location Program.

5.3.c.1 A single training location program is a program that structures the training of the resident at a single practice location (as defined in 5.3).

5.3.c.2 A multiple training location program is a program that is structured to use one or more additional practice locations for training an individual resident beyond the resident’s home-base practice location.

5.3.c.2.1 All additional practice locations used for training in a multiple training location program meet the requirements set forth in pharmacy services requirements in Standard 6.

Standard 6: Pharmacy Practice

6.1 Pharmacy Practice Structure and Management
Pharmacy practice is led and managed by a professional, legally qualified pharmacist.

The practice has a well-defined organizational structure that supports the safe and effective provision of services including:

- **6.1.b.1** mission statement;
- **6.1.b.2** current policies and procedures that are readily available to staff participating in service provision;
- **6.1.b.3** descriptions of roles and responsibilities for all categories of pharmacy personnel, including residents;
- **6.1.b.4** procedures to ensure that medication-use systems (ordering, dispensing, administration, and monitoring) are safe and effective; and,
- **6.1.b.5** procedures to ensure that pharmacists’ patient care services are safe, effective, and evidence-based.

The practice has a strategic plan and documentation of progress on long-term and short-term goals.

- **6.1.c.1** For organizations where the pharmacy department is part of a larger practice, the practice strategic planning committee includes pharmacist representatives in the planning of patient care services.

The practice is in compliance with all applicable federal, state, and local laws, codes, statutes, and regulations governing pharmacy practice unique to the practice site.

The practice is in compliance with current national practice standards and guidelines.

Pharmacy Resources
Pharmacy practice has sufficient resources required to provide services pursuant to the needs of the patient population of the practice. The practice:

- **6.2.a** is designed, constructed, organized, and equipped to promote safe and efficient work;
- **6.2.b** is designed to accommodate confidential patient assessment, counseling, and provision of patient care;
- **6.2.c** has professional, technical, and clerical staff sufficient and diverse enough to ensure that the practice can provide the level of service required by patients served;
- **6.2.d** has access to appropriate medical informatics, patient assessment tools/equipment, and technology necessary to provide the scope of services;
- **6.2.e** has a system to appropriately document patient care and other services of the practice; and,
- **6.2.f** has systems to support the connectivity and interoperability of information systems.

Pharmacy Services
Pharmacy services, when applicable, extend to all areas of the practice internally and externally to the pharmacy in which medications for patients are prescribed, dispensed, administered, and monitored.

- **6.3.a.1** Pharmacy services are integrated and provided collaboratively between internal and external areas of the practice.

Patient care services are developed and implemented in the practice based on the mission of the practice and an assessment of pharmacist services needed to provide
care to patients served by the practice. Patient care services include but are not limited to:

6.3.b.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;
6.3.b.2 health and wellness;
6.3.b.3 immunizations;
6.3.b.4 disease state management incorporating medication management; and
6.3.b.5 care transitions with incorporated medication reconciliation and medication management.

6.3.c The patient-centered dispensing system includes the following components:
6.3.c.1 a system where pharmacists are responsible for the safe and effective procurement, preparation, distribution, and control of all medications used or administered throughout the practice;
6.3.c.2 a system fostering accountability and optimization of safe medication-use system technologies;
6.3.c.3 routine patient counseling and education services on medication initiation, with any change to medication therapy, for high-risk medications and for high-risk patients; and,
6.3.c.4 evidence-based targeted interventions integrated into the patient-centered dispensing process.

6.4 Pharmacists’ Roles/Responsibilities
Pharmacists providing professional services at the practice will:
6.4.a manage selection, procurement, storage, and dispensing of medications used within the organization;
6.4.b prospectively review, evaluate, and assess the appropriateness and safety of medication prescriptions/orders;
6.4.c assist patients with self-care decisions;
6.4.d administer medications based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;
6.4.e manage adverse drug event monitoring, resolution, reporting, and prevention programs;
6.4.f develop and define protocols for the delivery of patient care services;
6.4.g follow the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists’ Patient Care Process using the principles of evidence-based practice;
6.4.h identify and take responsibility for resolution of drug therapy problems;
6.4.i perform physical assessments and conduct, order, and interpret laboratory tests based on collaborative practice agreements or other treatment protocols consistent with the law, regulations, and practice policies and procedures;
6.4.j participate in initiating, modifying, and discontinuing drug therapy, based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;
6.4.k proactively provide education and counseling to patients regarding medications and related products;
6.4.i document patient care in the patient’s health care record;
6.4.m communicate with patients and families as appropriate to address and resolve potential barriers to safe and effective medication use (e.g., literacy, access, language needs);
6.4.n collaborate, document, and communicate with physicians, other pharmacists, patients, and other health care professionals as a member of an interprofessional team in the provision of safe, effective, and coordinated patient-centered care;
6.4.o provide educational programs about medications, medication therapy, health, and other related matters to patients, caregivers, and health care providers; and,
6.4.p participate in projects and activities relating to improving population health.

6.5 Continuous Quality Improvement
6.5.a Practice personnel engage in an ongoing process to assess the quality of pharmacy services.
   6.5.a.1 The practice has procedures to document, track, evaluate, and report patient care outcomes data.
6.5.b Practice personnel develop and implement pharmacy services improvement initiatives in response to assessment results.
6.5.c Practice assessment and improvement processes routinely include assessing and developing skills of the practice’s staff.
References


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This Standard replaces the previous Accreditation Standard for Postgraduate Year One (PGY1) Community Pharmacy Residency Programs that was approved by the ASHP Board of Directors on September 22, 2006 and the APhA Board of Trustees on September 15, 2006 and the first release of this Standard in January 2016 (for minor revisions). For existing programs, in operation as of the date of the
approval and new programs commencing on July 1, 2016, the implementation of this new Standard will take effect on July 1, 2017. Until that date, the existing Standard approved in September 2006 remains in effect.
Glossary

Assessment. Measurement of progress on achievement of educational objectives.

Certification. A voluntary process by which a nongovernmental agency or an association grants recognition to an individual who has met certain predetermined qualifications specified by that organization. This formal recognition is granted to designate to the public that the individual has attained the requisite level of knowledge, skill, or experience in a well-defined, often specialized, area of the total discipline. Certification usually requires initial assessment and periodic reassessments of the individual’s qualifications.

Clinical pharmacist. Clinical pharmacists work directly with doctors, other health professionals, and patients to ensure that the medications prescribed for patients contribute to the best possible health outcomes. (American College of Clinical Pharmacists)

Competency area. Category of residency graduates’ capabilities.

Complex condition. Patients with complex conditions are those who are being treated with high-risk medications, high numbers of medications, and/or have multiple disease states.

Criteria. Specific, qualitative comments that describe competent performance for each objective.

Critical factors. Elements of accreditation standards that the ASHP Commission on Credentialing has determined to be more important and, therefore, carry more weight than others when they are assessed as being less than fully compliant and used to determine length of accreditation.

Educational Goal. Broad statement of abilities.

Educational Objective. Observable, measurable statement describing what residents will be able to do as a result of participating in the residency program.


Formative assessment. On-going feedback to residents regarding their progress on achievement of educational objectives for the purpose of improving learning.

Interdisciplinary team. A team composed of members from different professions and occupations with varied and specialized knowledge, skills, and methods. The team members integrate their observations, bodies of expertise, and spheres of decision making to coordinate, collaborate, and communicate with one another in order to optimize care for a patient or group of patients. (Institute of Medicine. Health professions education: a bridge to quality. Washington, DC: The National Academy Press; 2001.)
**Multiple-site residency.** A residency site structure in which multiple organizations or practice sites are involved in the residency program. Examples include programs in which: residents spend greater than 25% of the program away from the sponsoring organization/main site at another single site; or there are multiple residents in a program and they are home-based in separate sites.

1. To run a multiple-site residency there must be a compelling reason for offering the training in a multiple-site format (that is, the program is improved substantially in some manner). For example:
   a. RPD has expertise, however the site needs development (for example, site has a good variety of patients, and potentially good preceptors, however the preceptors may need some oversight related to the residency program; or services need to be more fully developed); b. quality of preceptorship is enhanced by adding multiple sites;
   c. increased variety of patients/disease states to allow wider scope of patient interactions for residents;
   d. increased administrative efficiency to develop more sites to handle more residents across multiple sites/geographic areas;
   e. synergy of the multiple sites increases the quality of the overall program;
   f. allows the program to meet all of the requirements (that could not be done in a single site alone); and,
   g. ability to increase the number of residents in a quality program.

2. A multiple-site residency program conducted in multiple hospitals that are part of a health-system that is considering CMS pass-through funding should conduct a thorough review of 42CFR413.85 and have a discussion with the finance department to ensure eligibility for CMS funding.

3. In a multiple-site residency program, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program. This includes:
   a. designating a single residency program director (RPD);
   b. establishing a common residency purpose statement to which all residents at all sites are trained;
   c. ensuring a program structure and consistent required learning experiences;
   d. ensuring the required learning experiences are comparable in scope, depth, and complexity for all residents, if home based at separate sites;
   e. ensuring a uniform evaluation process and common evaluation tools are used across all sites;
   f. ensuring there are consistent requirements for successful completion of the program;
   g. designating a site coordinator to oversee and coordinate the program’s implementation at each site that is used for more than 25% of the learning experiences in the program (for one or more residents); and,
   h. ensuring the program has an established, formalized approach to communication that includes at a minimum the RPD and site coordinators to coordinate the conduct of the program across all sites.

**Non-traditional residency:** Residency program that meets requirements of a 12-month residency program in a different timeframe.

**Pharmacist Executive.** The person who has ultimate responsibility for the residency practice site/pharmacy in which the residency program is conducted. (In some settings this person is referred to, for example, as the director of pharmacy, the pharmacist-in-charge, the chief of pharmacy services) In a
multiple-site residency, a sponsoring organization must be identified to assume ultimate responsibility for coordinating and administering the program.

**Preceptor.** An expert pharmacist who gives practical experience and training to a pharmacy resident. Preceptors have responsibility for the evaluation of residents’ performance.

**Preceptor-in-training.** Pharmacists who are new to precepting residents who have not yet met the qualification for a preceptor in an accredited program. Through coaching and a development plan, they may be a preceptor for a learning experience and become full preceptors within two years.

**Residency program director.** The pharmacist responsible for direction, conduct, and oversight of the residency program. In a multiple-site residency, the residency program director is a pharmacist designated in a written agreement between the sponsoring organization and all of the program sites.

**Resident’s Development Plan.** Record of modifications to residents’ program based on their learning needs.

**Self-evaluation.** A process of reflecting on one’s progress on learning and/or performance to determine strengths, weaknesses, and actions to address them.

**Service commitments.** Clinical and operational practice activities. May be defined in terms of the number of hours, types of activities, and a set of educational goals and objectives.

**Single-site residency.** A residency site structure in which the practice site assumes total responsibility for the residency program. In a single-site residency, the majority of the resident’s training program occurs at the site; however, the resident may spend assigned time in short elective learning experiences offsite.

**Site.** The actual practice location where the residency experience occurs.

**Site Coordinator.** A preceptor in a multiple-site residency program who is designated to oversee and coordinate the program’s implementation at an individual site that is used for more than 25% of the learning experiences. This individual may also serve as a preceptor in the program. A site coordinator must:

1. be a licensed pharmacist who meets the minimum requirements to serve as a preceptor (meets the criteria identified in Principle 5.9 of the appropriate pharmacy residency accreditation standard);
2. practice at the site at least ten hours per week;
3. have the ability to teach effectively in a clinical practice environment; and,
4. have the ability to direct and monitor residents’ and preceptors’ activities at the site (with the RPD’s direction).

**Sponsoring organization.** The organization assuming ultimate responsibility for the coordination and administration of the residency program. The sponsoring organization is charged with ensuring that residents’ experiences are educationally sound and are conducted in a quality practice environment. The sponsoring organization is also responsible for submitting the accreditation application and
ensuring periodic evaluations are conducted. If several organizations share responsibility for the financial and management aspects of the residency (e.g., school of pharmacy, health-system, and individual site), the organizations must mutually designate one organization as the sponsoring organization.

**Staffing.** See “Service commitments.”

**Summative evaluation.** Final judgment and determination regarding quality of learning.
REQUIRED COMPETENCY AREAS, GOALS, AND OBJECTIVES FOR POSTGRADUATE YEAR ONE (PGY1) COMMUNITY-BASED PHARMACY RESIDENCIES

Prepared jointly by the American Society of Health-System Pharmacists (ASHP) and the American Pharmacists Association (APhA)

Introduction

The competency areas, goals, and objectives are for use with the Accreditation Standard for Postgraduate Year One (PGY1) Community-based Pharmacy Residency Programs. The four competency areas and their associated goals and objectives are required and must be included in all programs. Programs may add additional goals and objectives under one or more required competency areas. In addition, elective or customized goals and objectives may be selected for specific residents only. All required and any additional goals and objectives selected by the program must be evaluated at least once during the residency year.

Each objective has been classified according to educational taxonomy (cognitive, affective, or psychomotor) and level of learning. An explanation of the taxonomies is available elsewhere. Objectives are achieved through the completion of activities. The Standard requires that specific activities be developed that match the Bloom’s Taxonomy learning level for each objective. Activities are the answer to the question, “What can residents do in the context of this learning experience that will provide the kind of experiences necessary to achieve the educational objective?”.

Progress toward achievement of a specific objective is assessed using criteria. The use of criteria-based evaluations is required by the Standard for both formative and summative assessment. The example criteria provided for each objective are intended to help preceptors and residents identify specific areas of successful skill development and areas requiring performance improvement. Preceptors may also develop their own criteria to assess resident performance, identify areas requiring performance improvement, and meet the intent of the standard.


2 David R. Krathwohl (2002): A Revision of Bloom’s Taxonomy: An Overview, Theory Into Practice, 41:4, 212-218
Definitions

**Competency Area:** Categories of the residency graduates’ capabilities.

**Educational Goals (Goal):** Broad statement of abilities.

**Educational Objectives (Objective):** Observable, measurable statement describing what residents will be able to do as a result of participating in the residency program.

**Activities:** What residents will do to learn and practice to achieve a specific objective.

**Criteria:** Indicators reflecting the quality of the residents’ performance.

**Competency Area R1: Patient Care**

**Goal 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. Services are provided to a diverse range of patients in collaboration with the health care team.

*Note: Objectives R1.1.3 through R1.1.7 align with the steps of the JCPP Pharmacists’ Patient Care Process while Objectives R1.1.1, R1.1.2, and R1.1.8 through R1.1.10 support the delivery of the JCPP Pharmacists’ Care Process.*

**Objective R1.1.1: (Responding and Applying) Demonstrate responsibility and professional behaviors as a member of the health care team.**

**Criteria:**
- Demonstrates professionalism through appearance and personal conduct.
- Interacts cooperatively, collaboratively, and respectfully.
- Holds oneself and colleagues to the highest principles of the profession’s moral, ethical, and legal conduct.
- Places patient needs above own needs and those of other health professionals.
- Accepts consequences for his or her actions without redirecting blame to others.
- Maintains competency as a pharmacist.
- Stays current with the biomedical literature relative to current areas of practice.
- Prioritizes patient care activities appropriately as a part of daily responsibilities.
- Takes appropriate ownership of the care for patients.
- Works actively to identify and pursue resolution of significant medication-related problems.
- Assumes responsibility for patient care outcomes.

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Objective R1.1.2: (Responding and Applying) Establish a patient-centered relationship with the individual patient, family members, and/or caregivers.
Criteria:
- Demonstrates respect and empathy appropriately.
- Establishes rapport and trusting relationships with the patient, family members, and/or caregivers (i.e., establishes therapeutic alliances).
- Engages patient appropriately in making care decisions.
- Displays respect for the preferences and expressed needs of the patient.
- Exhibits cultural competency and respect for diversity when interacting with patients, family members, and/or caregivers.
- Keeps commitments made to patients.
- Respects patients’ privacy.

Objective R1.1.3: (Valuing and Analyzing) Collect relevant subjective and objective information for the provision of individualized patient care.
Criteria:
- Identifies and accesses appropriate sources of information.
- Collects accurate and complete subjective and objective information for the provision of patient care including the following:
  - complete current medication list and medication use history including prescription and nonprescription medications, herbal products, and other dietary supplements;
  - relevant health data including medical history, health and wellness information, biometric test results, physical assessment findings, and pharmacogenomics/pharmacogenetics information; and,
  - patient lifestyle habits, preferences and beliefs, health and functional goals, and socioeconomic factors that affect access to medication(s) and other aspects of care.
- Performs appropriate physical assessment.
- Orders laboratory tests, if applicable.
- Conducts appropriate point of care testing, if applicable.
- Organizes information thoroughly, efficiently and effectively from all relevant sources while excluding extraneous information.
- Uses a systematic process for recording information that is functional for subsequent problem solving and decision-making.
- Displays understanding of limitations for information collected from the patient and health records.
- Clarifies information appropriately when needed.

Objective R1.1.4: (Analyzing) Analyze and assess information collected and prioritize problems for provision of individualized patient care.
Criteria:
- Analyzes the information and assesses the clinical effects of the patient’s therapy in the context of the patient’s overall health goals and to achieve optimal care including assessing:
  - each medication for appropriateness, effectiveness, safety, and patient adherence;
  - health and functional status, risk factors, health data, cultural factors, health literacy, and access to medications or other aspects of care; and,
immunization status and the need for preventive care and other health care services, where appropriate.

- Identifies unmet health care needs of patient.
- Identifies medication therapy problems accurately.
- Prioritizes the patient’s needs correctly based on professional judgments as well as the patient’s values, preferences, priorities and goals.
- Prioritizes the problem list correctly including identifying which problems the pharmacist can manage and which problems require referral.

Objective 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.
Criteria:

- Chooses and follows the most appropriate and up-to-date guidelines to create the care plan.
- Establishes evidenced-based and cost effective care plans that:
  - address medication-related problems and optimize medication therapy appropriately;
  - have realistic, measurable goals of therapy for achieving clinical outcomes in the context of the patient’s overall health care goals and access to care;
  - engage the patient through education, empowerment, and self-management;
  - support care continuity, including follow-up and transitions of care, as appropriate;
  - meet the patient’s health care goals including self-care options as appropriate;
  - are appropriate for the disease states being treated and/or prevented; and,
  - are created in collaboration with other health care professionals, the patient and caregivers.

Objective R1.1.6: (Applying) Implement the care plan in collaboration with other health care professionals, the patient, and caregivers.
Criteria:

- Implements the care plan by effectively engaging the patient through education, empowerment, and self-management including:
  - addressing medication problems and optimizing medication therapy;
  - initiating, modifying, discontinuing, or administering medication therapy as authorized; and,
  - addressing-health related problems through preventive care strategies, vaccine administration, and lifestyle modifications.
- Contributes to coordination of care, including the referral or transition of the patient to another health care professional.
- Determines and schedules appropriate follow-up care or referrals as needed to achieve goals of therapy.
- Communicates appropriate details of the care plan effectively and efficiently with all relevant health care professionals.

Objective 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.
Criteria:

- Monitors patient progress and adjusts care plan appropriately in collaboration with other health care professionals, the patient and caregivers by:
o reassessing all medications for appropriateness, effectiveness, safety, and patient adherence through available health data, biometric test results, and patient feedback;
o evaluating clinical endpoints and outcomes of care including progress toward or the achievement of goals of therapy;
o identifying appropriate modifications to the care plan;
o establishing a revised plan in collaboration with other health care professionals, the patient and/or caregivers.

- Communicates relevant modifications to the care plan to the patient, caregivers, and other relevant health care professionals.
- Establishes appropriate schedule for follow-up care or referral as needed to achieve goals of therapy.

Objective R1.1.8: (Valuing and Applying) Collaborate and communicate effectively with patients, family members, and caregivers.
Criteria:
• Uses clear and concise language at the appropriate literacy level.
• Uses most appropriate communication techniques to engage the patient and elicit accurate and meaningful data and to provide education.
• Identifies appropriate communication support services to facilitate communication with diverse patient populations in the practice.
• Uses appropriate interviewing techniques (such as using open-ended questions, identifying non-verbal cues).
• Uses appropriate motivational interviewing techniques to facilitate health behavior change.
• Verifies accurately patient understanding.
• Supports and assists patients effectively with health behavior changes.
• Provides appropriate supplemental written communication materials.

Objective R1.1.9: (Valuing and Applying) Collaborate and communicate effectively with other health care team members.
Criteria:
• Adheres consistently and appropriately to the Core Principles & Values for Effective Team-based Health Care.4
• Makes recommendations clearly, concisely, persuasively, and in a timely manner.
• Demonstrates appropriate skills in negotiation, conflict management, and consensus building.
• Defuses negative reactions effectively.
• Communicates assertively, but not aggressively.
• Advocates effectively on behalf of patients to other members of the health care team.

Objective R1.1.10: (Applying) Document patient care activities appropriately and efficiently.
Criteria:
• Selects appropriate information to document.

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• Documents clearly and in an appropriate format.
• Documents in a timely fashion.
• Follows the practice’s documentation policies and procedures.
• Documents appropriately to support coding, billing, and compensation.
• Ensures security of Protected Health Information (PHI) throughout the documentation process.

Goal R1.2: Provide safe and effective patient care during the delivery of patient-centered dispensing.

Objective R1.2.1: (Analyzing) Prior to dispensing a medication, perform an effective drug utilization review aligned with the JCPP Pharmacists’ Patient Care Process to identify, detect, and address therapeutic problems.
Criteria:
• Collects and assesses appropriate information to identify and detect actual or potential therapeutic problems.
• Creates and implements a plan to make appropriate interventions to resolve potential or actual therapeutic problems.
• Documents appropriately interventions made and outcomes of the intervention.

Objective R1.2.2: (Applying) Prepare and dispense or administer (when appropriate) medications to support safe and effective patient-centered care.
Criteria:
• Receives the prescription and obtains all required information.
• Interprets prescription and performs order entry accurately.
• Prepares medications using appropriate techniques and follows the pharmacy’s policies and procedures and applicable professional standards in accordance with patient needs.
• Completes all steps in the final check of filled prescriptions to ensure accuracy.
• Administers medications using appropriate techniques.
• Stores prepared medications appropriately.
• Completes independently all steps of the patient-centered dispensing process accurately and efficiently.

Objective R1.2.3: (Applying) Identify and provide services related to patient-centered dispensing that assist individual patients in the safe and effective use of medications.
Criteria:
• Identifies patients’ needs for appropriate available services in the practice to facilitate safe and effective use of medications (e.g., compliance packaging, delivery services, compounded formulations, home care, DME, adherence programs).
• Recommends and engages patients in appropriate services to help improve patient outcomes.
• Provides needed services.
• Assists patients in navigating the health care system, as appropriate.
Objective R1.2.4: (Analyzing) Counsel and educate the patient and/or caregiver about dispensed medications, self-care products, medication adherence, and appropriate referrals for services.
Criteria:
• Recognizes appropriately when patients need medication counseling and education and maintains compliance with state laws and regulations related to patient counseling.
• Educates the patient and/or caregiver effectively about both dispensed and self-care medications.
• Employs effective counseling techniques (e.g., teach-back technique, IHS method).
• Assists patients in making appropriate self-care product selections.
• Determines barriers to patient adherence and makes appropriate adjustments.
• Takes appropriate actions to refer patients for other health care services or care by other health care professionals.

Goal R1.3: Provide safe and effective medication-related patient care when patients transition between care settings.

Objective R1.3.1: (Analyzing) Identify needs of individual patients experiencing care transitions.
Criteria:
• Recognizes routinely the patients in the community-based practice who are experiencing care transitions.
• Obtains an accurate and appropriate history to identify individualized needs of the patient experiencing care transitions.
• Conducts medication reconciliation thoroughly and effectively.
• Provides medication management when appropriate.
• Identifies potential and actual medication-related problems.

Objective R1.3.2: (Applying) Manage and facilitate care transitions between patient care settings.
Criteria:
• Identifies appropriate resources for patients in transition and makes appropriate connections to resolve issues.
• Takes appropriate actions on identified medication-related problems.
• Provides accurate and timely follow-up information when patients transfer to another facility, level of care, pharmacist, or other health care professional, as appropriate.
• Provides effective education to the patient and/or caregiver in transition.
• Follows up with patient in a timely and caring manner.
• Takes appropriate and effective steps to help avoid unnecessary hospital admissions and/or readmissions.
• Documents appropriately services provided, actions taken, interventions performed, referrals made, and outcomes achieved, as applicable.
Competency Area R2: Leadership and Management

Goal R2.1: Manage operations and services of the practice.

Objective R2.1.1: (Applying) Manage dispensing and patient care services at the community-based practice site.
Criteria:
- Adheres to legal, regulatory, and accreditation requirements.
- Follows the organization’s established policies and procedures.
- Demonstrates accurate knowledge and understanding of pharmacy and medication use systems for providing distributive and patient care services.
- Uses information systems and web platforms efficiently.
- Monitors effectively and efficiently the accuracy of the work of pharmacy technicians, clerical personnel, student pharmacists, and others according to applicable laws and organizational policies.
- Understands and adheres to coding, billing, and reimbursement regulations.
- Adheres to appropriate safety and quality assurance practices.
- Promotes effectively a culture of safety.
- Identifies system errors prior to an event.
- Prioritizes appropriately workload and organizes and oversees effective and efficient delivery of patient care and dispensing services.
- Assists appropriately with training and evaluation of staff at the practice site.
- Identifies and contributes suggestions for the creation or enhancement of policies, procedures, and protocols related to services provided.

Objective R2.1.2: (Applying) Participate in organizational level management activities, functions, and/or decision-making.
Criteria:
- Knows the organizational structure.
- Explains the strategic planning process of the organization correctly.
- Explains the quality improvement plan of the organization correctly.
- Explains current credentialing and privileging processes of the organization and potential changes for the future correctly.
- Determines, investigates, reports, tracks, and trends adverse drug events, medication errors, and efficacy concerns accurately using accepted organizational resource and programs.
- Participates effectively on committees or informal work groups to complete group projects, tasks, or goals.
- Assesses programmatic data against benchmarks correctly.
- Develops and presents background information for group projects, tasks, or goals accurately and effectively.
- Helps to properly identify and define significant organizational needs.
- Helps to develop appropriate policies, guidelines, protocols, or plans that address organizational needs.
- Participates effectively in implementing changes, using change management and quality improvement best practices and tools, consistent with team and organizational goals.
Objective R2.1.3: (Understanding) Identify relevant external factors that influence or impact community-based practice and identify appropriate strategies to adjust, comply, or improve.

Criteria:
- Explains correctly how changes to laws and regulations related to medication use, pharmacy practice, and health care impact the practice and services provided.
- Explains correctly the purpose of external quality metrics and how they are developed, abstracted, reported, and used in the context of a value-based health care system.
- Identifies appropriate stakeholders or entities outside of the practice that impact the practice and its functions.
- Identifies appropriate resources to keep updated on trends and changes within pharmacy and health care.
- Articulates correctly the current external issues that impact community-based practice.
- Understands the changes needed to adjust, comply, or improve the practice in response to external factors.

Objective R2.1.4: (Creating) Evaluate an existing, or develop a new collaborative practice agreement, standing order, or implementation process for a state-based protocol to expand the scope of practice for community-based pharmacists.

Criteria:
- Articulates correctly the purpose, state laws, regulations and other requirements of collaborative practice agreements, standing orders, and state-based protocols.
- Develops or evaluates accurately an existing collaborative practice agreement, standing order, or state-based protocol that reflects applicable state laws, regulations, and other requirements.
- Uses appropriate evidence-based treatment guidelines in the development or evaluation of an existing collaborative practice agreement, standing order, or state-based protocol.
- Describes correctly how the collaborative practice agreement, standing order, or state-based protocol reflects a mutual understanding of all stakeholders.
- Discusses accurately how the new collaborative practice agreement, standing order, or state-based protocol could be potentially implemented as part of pharmacy operations.

Goal R2.2: Demonstrate personal and professional leadership skills.

Objective R2.2.1: (Valuing and Applying) Manage one’s self effectively and efficiently.

Criteria:
- Adheres to organizational policies and procedures.
- Works effectively within the organization’s political and decision-making structure.
- Demonstrates personal commitment to the mission and vision of the organization.
- Demonstrates effective workload and time management skills and manages time to appropriately meet responsibilities within the confines of a reasonable workday.
- Prioritizes and organizes all tasks appropriately.
- Selects appropriate daily activities.
- Delegates appropriate work to technical and clerical personnel.
- Prepares appropriately to fulfill responsibilities (e.g., patient care, projects, management, and meetings).
- Sets and meets realistic goals.
• Sets and manages appropriate timelines in harmony with other involved individuals.
• Assumes and takes on increased levels of responsibility proactively.
• Assumes responsibility for quality of work and necessary improvement.
• Recognizes desired life balance and aligns it appropriately with future goals.
• Balances personal needs appropriately with the needs of the organization.

Objective R2.2.2: (Valuing and Applying) Apply a process of on-going self-evaluation and personal performance improvement.
Criteria:
• Demonstrates ability to accurately self-reflect and self-assess to summarize own strengths and areas for improvement in knowledge, values, qualities, skills, and behaviors.
• Engages effectively in self-evaluation process to determine progress on specified goals and plans.
• Sets realistic expectations of performance.
• Demonstrates ability to accept and incorporate constructive feedback from others.
• Integrates new knowledge and skills to meet expectations appropriately.
• Uses self-evaluation effectively to develop professional direction, goals, and plans.
• Uses effectively principles of continuing professional development (CPD) (reflect, plan, act, evaluate, record, and review).

Objective R2.2.3: (Valuing and Applying) Demonstrate effective leadership skills and behaviors.
Criteria:
• Demonstrates effective leadership while engaging with management and patient care teams (i.e., lead from where you stand).
• Leads working groups and/or committees effectively and efficiently.
• Embraces challenges and develops effective solutions.
• Embraces and advocates appropriately for changes that improve patient care.
• Manages conflict effectively.
• Builds consensus effectively.
• Demonstrates effective negotiation skills.
• Uses effective leadership communication skills and styles.
• Builds professional relationships effectively and appropriately.
• Influences others in a positive manner.
• Serves as a positive role model to student pharmacists, technicians, pharmacists, and other health care professionals.

Objective R2.2.4: (Valuing and Applying) Demonstrate commitment to the profession through active participation in the activities of a national, state, and/or local professional association.
Criteria:
• Articulates correctly the benefits of active participation in professional associations at all levels.
• Demonstrates accurate knowledge and awareness of the significance of local, state, and national advocacy activities impacting pharmacy and health care.
• Participates appropriately in practice and advocacy activities of national, state, and/or local professional associations.
Objective R2.2.5: (Valuing and Applying) Demonstrate commitment to the community through service.
Criteria:
• Understands the importance of community involvement as a core tenant of being a community-based pharmacist practitioner.5
• Articulates effectively the contribution that community service makes to personal and professional growth and development.
• Engages in a community service activity that aligns with the resident’s personal goals and schedule.
• Fulfills commitments made to provide community service.

Competency Area R3: Advancement of Community-based Practice and Improving Patient Care

Goal R3.1: Conduct a quality improvement project in the medication use system or in a patient care service to improve care and safety.

Note: Ideally, Objectives R3.1.1 through R3.2.3 should be completed for the same project. If necessary, multiple projects can be used to meet the individual objectives.

Objective R3.1.1: (Creating) Identify the need and develop a plan for a quality improvement project focused on the medication-use process and/or patient care services.
Criteria:
• Articulates and demonstrates accurate knowledge of continuous quality improvement (CQI) principles and the practice’s CQI policies and procedures.
• Compares practice functions appropriately with established best practices, evidence-based resources, and accreditation guidelines when appropriate to identify opportunities for improvements (e.g., ISMP, national guidelines).
• Analyzes relevant data appropriately to identify opportunities for improvement.
• Identifies an appropriate topic for a quality improvement project.
• Identifies the scope of the issue (i.e., What is the change to implement?) to be addressed within the quality improvement topic.
• Develops a feasible design for the project using evidence-based principles when appropriate and a systematic approach that considers who or what will be affected by the project.

Objective R3.1.2: (Applying) Implement a quality improvement project.
Criteria:
• Obtains appropriate reviews and approvals from department, organization, and/or external entities.
• Follows the designed implementation plan effectively and efficiently.

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• Uses appropriate electronic data and information from internal information databases, external online databases, internet resources, and other sources of decision support, as applicable.
• Collaborates effectively with necessary members of the pharmacy and/or organization team to implement.
• Completes the project as specified in the implementation plan following established timeline and milestones.

Objective R3.1.3: (Evaluating) Evaluate the impact of a quality improvement project.
Criteria:
• Collects appropriate outcome data and analyzes the data to assess implemented change
• Identifies need for additional modifications or changes.
• Determines effectively the impact in terms of quality, safety, cost-effectiveness, significance, and sustainability.

Goal R3.2: Contribute to the development, implementation, and evaluation of a new pharmacy service or to the enhancement of an existing service.

Note: Ideally, Objectives R3.2.1 through R3.2.3 should be completed for the same service. If necessary, multiple services can be used to meet the individual objectives.

Objective R3.2.1: (Creating) Identify the need and develop a business plan for a new or enhanced service.
Criteria:
• Identifies an unmet need accurately for a new or enhanced service.
• Identifies anticipated outcome(s) appropriately for patients through implementation of a new or enhanced service.
• Identifies correct resources needed for developing and implementing a new or enhanced service.
• Engages team members effectively throughout the development process.
• Develops a training plan for team members who will be delivering the new or enhanced service.
• Identifies the necessary components of and develops a complete business plan for a new/enhanced service.
• Identifies appropriate stakeholders.
• Identifies and secures all necessary approvals before moving forward.
• Projects the financial impact and the value of the new/enhanced service appropriately for the pharmacy, organization, and patients.
• Identifies appropriate potential revenue sources or potential sources of compensation.
• Develops a marketing strategy that is appropriate for target audience and integrated with the overall practice’s marketing plan.
• Uses appropriate presentation and persuasive skills to secure approval of the proposal for the new or enhanced service.
Objective R3.2.2: (Applying) Implement the planned new or enhanced service.
Criteria:
• Implements the components of the business and marketing plans effectively and efficiently to initiate new or enhanced service.
• Engages team members effectively throughout the implementation process.
• Meets the established timeline and milestones as specified in the implementation plan.

Objective R3.2.3: (Evaluating) Evaluate the new or enhanced service to determine if it meets the stated goals and is sustainable.
Criteria:
• Collects appropriate outcome data to assess the new or enhanced service.
• Analyzes data appropriately to assess the success of new or enhanced service.
• Determines accurately the impact to the practice in terms of quality, safety, cost-effectiveness, significance, and sustainability.
• Identifies accurately the need for additional modifications or changes to improve the service.

Goal R3.3: Complete a practice innovation or research project that advances community-based practice using effective project management skills.

Note: The project referred to in Objectives R3.3.1 through R3.3.4 can be related to quality improvement project in goal R3.1 or with the development of a new or enhanced service in goal R3.2 if robust enough, sufficient data collection occurs, and all the objectives are met.

Objective R3.3.1: (Creating) Identify and design a practice-related project significant to community-based practice.
Criteria:
• Articulates correctly the importance of practice-based research and the sharing of new knowledge and practice experiences.
• Identifies potential projects that are in alignment with pharmacy’s patient care and/or operational goals.
•Analyzes relevant background information including evidenced-based resources and best practices to determine if project warrants investigation.
•Selects a project that can be completed in a reasonably expected timeframe.
•Identifies appropriately the scope of the issue (i.e., What is the research question?) to be addressed within the project.
•Identifies appropriate data and information from internal information databases, external online databases, internet resources, and other sources of decision support, as applicable, required for project.
•Develops a feasible design with sound methodology using evidence-based principles and a systematic approach written in the appropriate format.
• Creates a comprehensive implementation plan for the project that includes appropriate reviews and approvals required by department, organization, and/or external entities.
Objective R3.3.2: (Applying) Implement a practice-related project significant to community-based practice.
Criteria:
• Collaborates effectively with necessary members of the pharmacy and/or organization team to implement the project.
• Collects appropriate data and other information for project evaluation.
• Completes the project as specified in the implementation plan following established timeline and milestones.

Objective R3.3.3: (Evaluating) Accurately assess the impact of the practice-related project including sustainability, if applicable.
Criteria:
• Analyzes data and information collected to assess the success of the project.
• Determines and discusses the impact of the project in terms of quality, safety, cost-effectiveness, significance, and sustainability, if applicable.
• Identifies limitations of the project and potential modifications or changes.
• Draws appropriate conclusions from the analyzed data.

Objective R3.3.4: (Responding and Creating) Effectively develop and present, orally and in writing, a final project report.
Criteria:
• Develops an oral report for the project that is well organized and easy to follow.
• Presents oral project report with poise and confidence to an external audience.
• Responds to questions knowledgably and accurately.
• Summarizes key points at the close of the presentation.
• Develops a project poster in an appropriate format that is clear, concise, and easy to follow without typographical or design errors.
• Presents professionally a poster to an external audience.
• Writes a project manuscript that uses and meets the criteria required for the selected manuscript style.
• Completes all report requirements on time and within assigned timeframe.

Competency Area R4: Teaching, Education, and Dissemination of Knowledge

Goal R4.1: Provide effective education and/or training.

Objective R4.1.1: (Creating) Design effective education and/or training activities based on the learners’ level and identified needs.
Criteria:
• Writes educational objectives that are specific, measurable, at a relevant learning level, and address the audience’s defined learning need.
• Chooses content for instruction:
  o that is relevant, thorough, evidence-based, and reflects best practices;
  o based on an accurate assessment of the learner’s need and level of understanding;
  o that has accurate and sufficient information in the instructional materials to meet the needs of the audience; and,
that matches the intent of the stated educational objectives.

- Includes accurate citations and relevant references and adheres to applicable copyright laws.
- Designs instructional materials that appropriately match the cultural needs and literacy level of the audience.

**Objective R4.1.2: (Applying) Use effective presentation and teaching skills to deliver education programs to targeted audiences including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.**

**Criteria:**

- Selects teaching method to deliver the material based on the type and level of learning required (cognitive, psychomotor, and affective).
- Incorporates multiple appropriate educational techniques to present the program.
- Develops and uses effectively audio-visual and handouts to support learning activities.
- Demonstrates thorough understanding of the topic.
- Organizes and sequences instruction properly.
- Presents at appropriate level of the audience.
- Speaks at an appropriate rate and volume with articulation and engaging inflection.
- Uses effectively body language, movement, and expressions to enhance presentations.
- Makes smooth transitions between concepts and slides.
- Summarizes important points at appropriate times throughout presentations.
- Demonstrates ability to adapt appropriately during the presentation.
- Responds to questions from participants in a concise, accurate, and thoughtful manner.
- Creates an assessment plan that will accurately measure the participants’ attainment of the educational objectives.
- Demonstrates willingness to incorporate constructive feedback received from participants.

**Objective R4.1.3: (Applying) Develop effective written communication skills to provide educational information to multiple levels of learners including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.**

**Criteria:**

- Writes in a manner that is concise, easily understandable, and free of errors.
- Demonstrates thorough understanding of the topic.
- Notes appropriate citations and references.
- Includes critical evaluation of the literature and knowledge advancements or a summary of what is currently known on the topic.
- Develops and uses tables, graphs, and figures to enhance the reader’s understanding of the topic, when appropriate.
- Writes at a level appropriate for the target readership (e.g. patients, caregivers, and members of the community; pharmacists; and other health care professionals).
- Creates visually appropriate documents (e.g., font, white space, and layout).
- Creates one’s own work and does not engage in plagiarism.
- Seeks feedback from the targeted audience.
Goal R4.2: Effectively employ appropriate preceptor skills when engaged in experiential teaching (e.g., students, pharmacy technicians, or other health care professionals)

Objective R4.2.1: (Analyzing) Identify experiential learning activities and select appropriate preceptor roles to meet learners’ educational needs.
Criteria:
- Utilizes knowledge, skills, experiences, and values appropriately to prepare the next generation of pharmacists.
- Identifies experiential learning opportunities in the practice setting and engages learners appropriately.
- Creates an organized and systematic approach to designing learning experiences for the student.
- Moves with ease between the four preceptor roles as learner needs change.
- Provides effective, focused direct instruction when warranted.
- Models skills by including “thinking out loud,” so learners can “observe” critical-thinking skills.
- Coaches, including effective use of verbal guidance, feedback, and questioning, as needed.
- Facilitates, when appropriate, by allowing learner independence and using indirect monitoring of performance.
- Selects appropriate problem-solving situations for independent work by the learner.
- Chooses appropriate preceptor roles to stimulate professional growth in health care professional students and pharmacy technicians.

Objective R4.2.2: (Analyzing) Provide appropriate and timely formative and summative feedback and ensure learner understands the feedback during experiential learning.
Criteria:
- Identifies appropriate time to provide feedback to the learner.
- Uses appropriate methods to provide feedback.
- Engages the learner effectively in self-assessment.
- Provides criteria-based feedback correctly.
- Develops an action plan and monitoring plan in collaboration with the learner to encourage performance improvement.
- Identifies and takes appropriate actions when learner fails to meet performance expectations.

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Developed by APhA in partnership with the ASHP Commission on Credentialing and the APhA PGY1 Community Accreditation Standard Taskforce. The APhA PGY1 Community Accreditation Standard Taskforce was directed by James Owen, APhA Vice President of Practice and Science Affairs, and was facilitated by Marialice Bennett, Former APhA President and current ASHP Lead Surveyor. Members of the taskforce included Stephanie Barrus, Anne Burns, Rebecca Cupp, Laurie Fleming, Jean-Venable “Kelly” Goode, William Grise, Cherokee Layson-Wolf, William Miller, Janelle Ruisinger, Jeri Sias, Judy
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This document replaces the REQUIRED AND ELECTIVE EDUCATIONAL OUTCOMES, GOALS, OBJECTIVES AND INSTRUCTIONAL OBJECTIVES FOR POSTGRADUATE YEAR ONE (PGY1) COMMUNITY PHARMACY RESIDENCY PROGRAMS document that was approved by the ASHP Board of Directors on September 22, 2006 and the APhA Board of Trustees on September 15, 2006.

Implementation of both the ACCREDITATION STANDARD FOR POSTGRADUATE YEAR ONE (PGY1) COMMUNITY-BASED PHARMACY RESIDENCY PROGRAMS AND the REQUIRED COMPETENCY AREAS, GOALS, AND OBJECTIVES FOR POSTGRADUATE YEAR ONE (PGY1) COMMUNITY-BASED PHARMACY RESIDENCIES is required for all programs as of July 1, 2017.
St. Louis College of Pharmacy (STLCOP) sponsors this Community-Based Pharmacy Residency Program (CPRP) in cooperation with Schnucks Pharmacy (since 2011), L&S Pharmacy (since 2012), and Walgreens Pharmacy (since 2012), and Pharmax Pharmacy (since 2018). These institutions are referred to as “Schnucks” or “S”, “L&S”, “Walgreens” or “W”, “Pharmax” or “PP” in this document.

**Residency Program Director:** Nicole M. Gattas, Pharm.D., BCPS, FAPhA  
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**General Description of our Program**

This program is considered a “multi-site” program. This means we share a purpose statement and general set up of learning experiences. In addition to providing the Residency Program Director, St. Louis College of Pharmacy provides preceptor development, resident academic and educational opportunities. Residents will work as a team for various academic projects. Resident experiences will vary slightly in details and practice management. For example, documentation or MTM platform may vary, but all residents complete MTM comprehensive medication reviews. Practice management has different emphasis depending on the site as we have a national chain, regional chain, and independent pharmacies.

The resident gains independence throughout the year in direct patient care, practice management, and student precepting. The program focuses on longitudinal experiences in community care further described below. The site coordinator and the program director regularly meet with the resident to provide feedback and guidance.

The resident participates in multiple projects. Projects include but are not limited to: journal club, case presentations, topic discussions, drug information responses, resident seminars, research project, business plan, new or expanded patient care service, quality improvement project. The resident receives a faculty appointment and completes a teaching program offered through St. Louis College of Pharmacy. Teaching opportunities include classroom presentations, pharmacy practice lab instruction, and advanced practice experience precepting.

The resident has the ability to complete up to two electives to meet individual interests and needs. These elective experiences can either be rotational or longitudinal experiences. These opportunities will be determined by RPD and site coordinator based on ability to complete core competencies as well as availability and resident interest. Elective experiences will be related to community pharmacy, patient care, or academia.
L & S Pharmacy  
Charleston, Missouri

1. **General description:**
This independent community pharmacy offers unique experience for the resident. L&S Pharmacy offers medication therapy management (MTM) services, diabetes education, an innovative adherence program, and transitions of care program in a community setting. Medicare star ratings, CPESN, and reimbursement models as well as leadership and ownership in an independent setting are emphasized. The resident will work with the County Health Department to provide care for a 12-county population. The pharmacy resident learns to address patient-specific health care needs and extend patient care services to a community in great need. The resident will travel to St. Louis to participate in college activities. Additionally, housing in Charleston, Missouri is made available to the resident located at 901 E Cypress St, Charleston, MO 63834

2. **Specific locations and preceptors:**
   
   **L & S Pharmacy**  
   406 S. Main St.  
   Charleston, MO 63834  
   Phone: 573-683-3307

   **Richard "Tripp" Logan, III, Pharm.D.**  
   Pharmacist-in-Charge, Preceptor  
   E-Mail: tlogan@semorx.com

   **Richard Logan, Jr., Pharm.D.**  
   Pharmacist and Owner, Preceptor  
   E-Mail: rlogan@semorx.com

   **Eric Rowling, Pharm.D.**  
   Pharmacist, Preceptor-in-training  
   E-Mail: erolwing@semorx.com

   Others may be added based on interest.

3. **Estimated time spent on various activities**
   1. **Settings:**
      
      (a) 80% in the community pharmacy
      (b) 20% Other than the community pharmacy  
      Please specify: community outreach, College time, TOC program

   2. **Over the course of the residency year, what percentage of the resident’s time, if any, is dedicated to the following activities?**
      
      (a) 60% Direct patient care
      (b) 10% Program development
      (c) 5% Practice management
      (d) 5% Patient-centered dispensing
      (e) 5% Teaching/training
      (f) 5% Scholarly activity
      (g) 10% Organizational service
Pharmax Pharmacy  
Leadington, Missouri  

1. General description:  
This independent community pharmacy offers unique experience for the resident. Pharmax Pharmacy has six locations, but the resident will be based primarily in Leadington while serving the communities in Potosi and Bonne Terre occasionally. Pharmax Pharmacy offers medication therapy management (MTM) services, diabetes education, and an appointment-based medication synchronization program. The pharmacy participate in the state CPESN and MO PCN. Additionally, leadership and ownership in an independent setting are emphasized. The pharmacy resident learns to address patient-specific health care needs and extend patient care services to a community in great need. The resident will travel to St. Louis over the year to participate in college activities.

2. Specific locations and preceptors:  
   A. Pharmax Pharmacy, #1343 (Leadington)  
      113 St Francois Plaza  
      Leadington, MO 63601  
      Phone: (573) 431-5040  
      Fax: (573) 431-8967  
      
      Torey Watson, Pharm.D., MBA  
      Site Coordinator & Preceptor  
      Clinical Services Coordinator  
      Phone: (573) 701-7666  
      E-Mail: torey@pharmaxpharmacy.com  
      
      Jessica Barton, Pharm.D., CDE  
      Pharmacist and Preceptor  
      Pharmacist-in-Charge  
      Phone: (573) 431-5040  
      E-Mail: jbarton@pharmax-rx.com  
   
   B. Pharmax Pharmacy, #1302 (Potosi)  
      610 East High St.  
      Potosi, MO 63601  
      Phone: (573) 438-2189  
      Fax: (573) 438-5966  
      
      David Holman RPh.  
      Pharmacist and Preceptor  
      Pharmacist-in-Charge  
      Phone: (573) 438-2189  
      E-Mail: dbholman@pharmax-rx.com  
   
   C. Pharmax Pharmacy, #1365  
      60A Nesbit Drive  
      Bonne Terre, MO 63601  
      Phone: (573) 358-3301  
      Fax: (573) 358-7450
3. Estimated time spent on various activities

1. Settings:
   (a) 80% in the community pharmacy
   (b) 20% Other than the community pharmacy
       Please specify: community outreach, College time

2. Over the course of the residency year, what percentage of the resident’s time, if any, is dedicated to the following activities?
   (a) 60%  Direct patient care
   (b) 10%  Program development
   (c) 5%   Practice management
   (d) 5%   Patient-centered dispensing
   (e) 5%   Teaching/training
   (f) 5%   Scholarly activity
   (g) 10%  Organizational service
Schnucks Pharmacy  
Various locations in the St. Louis Metro area

1. General Description:
   Schnucks Pharmacy embraces the patient – pharmacist relationship which is enhanced by pharmacists who educate, counsel, and provide care to patients in their community pharmacy setting. Experiences include time at both clinic based pharmacies and specialty pharmacy, as well as community partner Food Outreach. This community pharmacy residency program advances the patient care and practice management abilities of the resident so that they can implement new and expanded pharmacy services in a community pharmacy setting. The resident will provide immunizations and perform medication reviews. The experiences in direct patient care utilizing specialized medications for conditions such as HIV or hepatitis, the process of providing services at community and centralized locations, and development of services at the corporate level in a chain store make this residency program uniquely designed to create leaders in community pharmacy.

2. Specific locations and preceptors:

   A. Schnucks #361 Regional Specialty Pharmacy (Page)  
      11550 Page Service Dr, Suite 101  
      St. Louis, MO 63146  
      Phone: 314-344-9201  
      Fax: 314-344-9204  

      Lauren Karpman, Pharm.D.  
      Site Coordinator & Preceptor  
      Specialty Pharmacy Manager  
      E-mail: llkarpman@schnucks.com

      Katie Kehl, Pharm.D.  
      Pharmacist and Preceptor  
      E-mail: krkehl@schnucks.com

      Drew Steppleman, Pharm.D.  
      Pharmacist and Preceptor  
      E-mail: tbd

      Bridget Flan  
      Pharmacist and Preceptor  
      E-mail: belam@schnucks.com

   B. Schnucks Specialty #304 Pharmacy (Brentwood)  
      1520 South Brentwood Blvd  
      St. Louis, MO 63144  
      Phone: (314) 918-1281

      Steven Fuchs, Pharm.D.  
      Pharmacist and Preceptor  
      E-mail: scfuchs@Schnucks.com
C. Schnucks Specialty #327 Pharmacy (Lindell)
   3960 Lindell Blvd.
   St. Louis, MO 63108
   Phone: 314-533-2992

   Kristen Badger, Pharm.D.
   Pharmacist and Preceptor
   E-mail: kbadger@schnucks.com

D. Patient Care Center at Food Outreach
   3117 Olive St.
   St. Louis, MO 63108

E. Schnuck Markets, Inc corporate office
   11420 Lackland Road
   St. Louis, MO 63146

   Noah Tennyson, Pharm.D., AAHIVP
   Director of Specialty Pharmacy and Preceptor
   314-415-0294
   E-mail: nmtennyson@schnucks.com

Others may be added based on interest.

3. Estimated time spent on various activities
   1. Settings:
      (a)  80% In the community pharmacy
      (b)  20% College, partner locations (e.g. Food Outreach) and corporate activities

   2. Over the course of the residency year, what percentage of the resident’s time, if any, is dedicated to the following activities?
      (a)  50% Direct patient care
      (b)  5% Program development
      (c)  5% Practice management
      (d)  20% Patient-centered dispensing
      (e)  10% Teaching/training
      (f)  5% Scholarly activity
      (g)  5% Organizational service
1. General Description:
Walgreens Pharmacy is committed to providing the PGY1 community pharmacy resident with an exceptional postgraduate educational training experience. The main practice site for the resident is the Walgreens Wellness Center, located approximately 1 mile from the St. Louis College of Pharmacy campus. This separate patient care area—located adjacent to the pharmacy—offers unique opportunities to practice advanced patient care in a variety of disease states. The resident will gain substantial experience in providing Medication Therapy Management (MTM), health screenings, health/wellness education, and immunizations to a diverse patient population. In addition, the resident will gain specialty pharmacy experience at the Walgreens pharmacy within Southampton Healthcare and Community, A Walgreens Pharmacy. At Southampton Healthcare, the pharmacy, is located within the physician practice, allows the resident to obtain extensive experience providing HIV and Hepatitis care to patients. At Community, A Walgreens Pharmacy the resident will be exposed to transplant and oncology care. Upon completion, the resident will have acquired an advanced skill set and be prepared to assume a leadership role in advancing the profession of pharmacy and community and specialty pharmacy practice.

2. Specific locations and preceptors:
A. Walgreens Pharmacy #06472 “Lindell”
Walgreens Wellness Center
4218 Lindell Blvd
St. Louis, MO 63108
Phone: 314-534-3829  Fax: 314-531-1367

Michelle Jeon, Pharm.D.
Site Coordinator & Preceptor:
Walgreens Wellness Pharmacist &
Assistant Professor of Pharmacy Practice, STLCOP
E-Mail: Michelle.Jeon@stlcop.edu

Andrew “Andy” Brand, Pharm.D.
Preceptor and Pharmacy Manager
E-Mail: Andrew.Brand@walgreens.com

B. Community, A Walgreens Pharmacy “Community”
115A North Euclid Ave
Saint Louis, MO 63108
314-454-6676

Daron Smith, R.Ph., AAHIVP
Preceptor and Registered Store Manager
E-Mail: Daron.Smith@walgreens.com

Lauren Lockus Koval, Pharm.D., AAVHIVP
Preceptor and Pharmacist
Email: lauren.lockus@walgreens.com
C. Various metro locations

**Kellye Holtgrave, RPh**
Preceptor and District Manager

Resident’s will travel to various locations with Ms. Holtgrave. Her home store is:
Walgreens Pharmacy
1108 Hartman Lane
Shiloh, IL 62221
Cell: 314-497-8017 (text ok)
Email: kellye.holtgrave@walgreens.com

D. Walgreens Pharmacy at Southampton HealthCare #12927 “Southampton”
Residents may also spend time at the following location:
Southampton Healthcare
2340 Hampton Ave.
Saint Louis, MO 63139
Phone: 314-647-1256  Fax: 314-644-0940
Preceptors: Daron Smith, or Lauren Lockus Koval

3. Estimated time spent on various activities

1. Settings:
   (a) 80% in community pharmacy practice setting
   (b) 20% Other than the community pharmacy
       Please specify: College, Community Outreach, Research

2. Over the course of the residency year, what percentage of the resident’s time, if any, is dedicated to the following activities?
   (a) 50% Direct patient care
   (b) 10% Program development
   (c) 10% Practice management
   (d) 10% Medication Use/Patient-centered dispensing
   (e) 10% Teaching/training
   (f) 5% Scholarly activity
   (g) 5% Organizational service
Resident Teaching Responsibilities
St. Louis College of Pharmacy
Coordinator: Nicole M. Gattas, Pharm.D., BCPS, FAPhA

1. General Description:
   Teaching & Learning Curriculum
   REA has a separate syllabus to guide resident learning and deadlines.

   Overview:
   Resident Education Academy (REA) is structured to prepare residents to teach audiences in
   both an academic and non-academic environment. Residents participate in a series of
   longitudinal workshops that introduce principles of Abilities-Based Education (ABE) with
   practice opportunities in preparing teaching materials. The teaching materials are used to
   teach an elective course to pharmacy students.

   During the fall, residents work with a partner and faculty mentor to create teaching materials,
   including a teaching script, lecture outcomes, lecture objectives, study guide, presentation
   slides, cases and exams.

   During the spring, the teaching materials developed in the fall are presented by the resident
   groups to P2 or P3 student pharmacists as part of a two-hour enhanced lecture. Other spring
   responsibilities include meeting with a faculty mentor prior to the resident group’s lecture
   presentation, observing a peer group’s scheduled class session and preparing a teaching
   portfolio that includes a teaching philosophy, samples of teaching materials and a self-
   reflection on teaching performance. All PGY1 pharmacy residents participate in REA.

Additional Academic Opportunities
Residents have opportunities to participate in additional teaching opportunities:
   • Lab instructor
     o Skills Lab 1 in the spring semester
   • Practicum or OSCE assessor for Skills lab
   • Lecturer as available and interested
   • Faculty Service: Residents that express interest may be invited to participate in
     various faculty meetings.
     o Opportunity to attend and participate in a minimum of one faculty and
       division meeting on campus
     o Opportunity to attend and participate in one faculty committee meeting on
       campus
   • Co-precepting for APPE and IPPEs at the various sites.
     o Creation and delivery of topic discussions with rotation students
     o Development of syllabi or schedule for students at site
   • There may be more opportunities for lectures, discussion group leaders, co-curricular
     activities, lunch and learns, etc. that come up and will be discussed on a case-by-
     case basis.
   • Precepting outreach opportunities provided by STLCOP (as available).
   • Additional opportunities for presentations and student interactions occur within other
     learning experiences, particularly within Health Care Professional Education and
     Seminar.
2. **Specific locations and preceptors:**

Various clinical faculty members may precept according to the project. The primary preceptor is:

Nicole M. Gattas, Pharm.D., BCPS, FAPhA  
Associate Professor of Pharmacy Practice  
Director, Community Pharmacy Residency Program  
Assistant Director of Community and Ambulatory Care, Office of Experiential Education  
4588 Parkview Place  
St. Louis, MO 63110  
Phone: 314-446-8555  Fax: 314-446-8500  Cell: 314-504-1202  
E-Mail: Nicole.Gattas@stlcop.edu
Required Learning Experiences:
   1. Orientation

Longitudinal Core:
   2. Patient Centered Dispensing
   3. Patient Care: Primary Care
   4. Patient Care: Specialty
   5. Outreach & Advocacy
   6. Leadership & Management

Projects & Teaching
   7. Research Project
   8. Quality Improvement Project
   9. Service Expansion
  10. Business Plan
  11. Residency Education Academy
  12. Health Care Practitioner (HCP) Education
  13. Additional Teaching

Elective rotations:
Up to two elective opportunities exist. These opportunities will be determined by RPD and site coordinator based on ability to complete core competencies as well as resident interest. Elective experiences will be related to community pharmacy or academia.

Recommended Elective(s): St. Louis University Health Resource Center (SLU HRC), an interprofessional indigent clinic, several times a semester on Saturday mornings. Description in the Appendices of this document.

Learning experience descriptions are available for each resident in separate documents.
## Residency Structure

<table>
<thead>
<tr>
<th>Learning Experience</th>
<th>Objectives: Taught and Evaluated unless denoted by a *, then taught but not evaluated. Highlighted colors show where objectives are evaluated more than one time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orientation</td>
<td>2.1.1 2.2.1</td>
</tr>
<tr>
<td><strong>Longitudinal Core</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Centered Dispensing</td>
<td>1.2.1 1.2.2 1.2.3 1.2.4 2.1.1 2.2.1 1.1.2* 1.1.8*</td>
</tr>
<tr>
<td>Patient Care: Primary Care</td>
<td>1.1.1 1.1.2 1.1.3 1.1.4 1.1.7 1.1.8 1.1.10 4.2.2 2.1.4*</td>
</tr>
<tr>
<td>Patient Care: Specialty</td>
<td>1.1.1 1.1.5 1.1.6 1.1.7 1.1.9 1.1.10 1.2.4 1.3.1 1.3.2 4.2.2 2.1.4*</td>
</tr>
<tr>
<td>Outreach &amp; Advocacy</td>
<td>2.2.4 2.2.5 4.1.2 4.2.1 4.1.3</td>
</tr>
<tr>
<td>Leadership &amp; Management</td>
<td>2.1.2 2.1.3 2.2.2 2.2.3</td>
</tr>
<tr>
<td><strong>Teaching &amp; Projects</strong></td>
<td></td>
</tr>
<tr>
<td>Research Project</td>
<td>3.3.1 3.3.2 3.3.3 3.3.4</td>
</tr>
<tr>
<td>Quality Improvement Project</td>
<td>3.1.1 3.1.2 3.1.3</td>
</tr>
<tr>
<td>Service Expansion</td>
<td>2.1.4 3.2.2 3.2.3</td>
</tr>
<tr>
<td>Business Plan</td>
<td>3.2.1</td>
</tr>
<tr>
<td>REA</td>
<td>4.1.1 4.1.2 4.1.3 4.2.2</td>
</tr>
<tr>
<td>HCP Education</td>
<td>4.1.1 4.1.2 4.1.3 2.2.2</td>
</tr>
<tr>
<td>Additional teaching</td>
<td>4.2.1 4.2.2 4.1.1 2.2.2</td>
</tr>
</tbody>
</table>
Residents must complete and/or achieve the following requirements in order to graduate from the program and receive a residency certificate. All requirements must be verified and acceptable to each Site Coordinator in conjunction with the Residency Program Director, and a copy should be included in the resident’s e-binder.

### Minimum Requirements for Completion of Residency

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Specific Minimum Requirements is successful completion of:</th>
<th>✓ If Completed Note projects</th>
</tr>
</thead>
</table>
| 1. Orientation                     | • Completed required trainings  
  • Attained required licensure                                                                                       |                             |
| 2. Patient-Centered Dispensing     | • Resident staffed independently at an appropriate pace  
  • Resident was able to navigate drug-related and insurance problems                                                  |                             |
| 3. Patient Care: Primary Care      | • Resident completed a minimum of 50 medication reviews  
  • Resident completed medication reviews independently and appropriately with follow-up  
  • Resident was able to practice independently with primary care activities                                             |                             |
| 4. Patient Care: Specialty         | • Resident was able to practice independently in specialty care  
  • Resident was able to navigate problems related to specialty care                                                   |                             |
| 5. Leadership & Management         | • Resident completed leadership and management projects assigned  
  • Resident is knowledgeable about the organizations and represents the organizations positively                         |                             |
| 6. Outreach & Advocacy             | • Resident participated in minimum amount of outreach activities  
  • Resident developed, organized, and participated in at least one outreach event  
  • Resident participates in at least one advocacy event                                                               |                             |
| **Residency Projects**             |                                                                                                                                                                                                                      |                             |
| 7. Quality Improvement Project     | • Resident participated in a QI project, including making recommendations for changes, and reporting findings                                               |                             |
| 8. Service Expansion               | • Participated in new or expansion of clinical services                                                                                                   |                             |
| 9. Business Plan                   | • Resident wrote and/or presents a business plan                                                                                                         |                             |
| 9. Research Project                | • CITI training completed  
  • IRB approval achieved  
  • Completed collection of and documentation of data & determined and interpreted statistics  
  • Prepared abstract  
  • Presented final project (APhA and/or residency conference)  
  • Wrote a manuscript  
  • IRB Summary of Investigative Work completed  
  • 3 ideas documented for future residents                                                                            |                             |
| 10. Resident Education Academy (REA)| • REA completed, including completion of a teaching portfolio and teaching philosophy                                                                  |                             |
### 11. HCP Education
- Completed additional teaching opportunities
- Completed a statistics presentation
- Presented a minimum of 2 journal clubs
- Presented a minimum of 2 formal cases
- Pharmacy Practice Formal Seminar presented (1 hour CE)
- Completed a minimum of 8 written DI responses and one DI paper

### Evaluations and Documentation

| Overall Evaluations | Completed, reviewed and co-signed 
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Development Plans</td>
<td>Completed development plans quarterly</td>
</tr>
<tr>
<td>Self-evaluations</td>
<td>Completed self-evaluations for each learning experience quarterly</td>
</tr>
<tr>
<td>Learning experience evaluations</td>
<td>Completed evaluations of each learning experience as required</td>
</tr>
<tr>
<td>All other evaluations</td>
<td>Completed, reviewed and co-signed</td>
</tr>
<tr>
<td>Documentation</td>
<td>Completed patient care documentation (Quantifi® and site specific) Completed binders (printed and/or electronic)</td>
</tr>
</tbody>
</table>

The resident completed above items to a satisfactory level.

Resident: ___________________________ Date: ____________

Site coordinator: ____________________ Residency Program Director: ____________________
EVALUATIONS

Evaluations help the resident, the preceptor, and the program to grow. It is essential that residents receive timely and specific feedback on their performances in order to have meaningful growth. Additionally, it is important that residents provide feedback to the preceptors, site coordinators and program directors so that changes can be made if necessary.

The resident must be evaluated either at the end of a rotation (e.g. orientation), or minimally quarterly by his/her preceptor. Presentations including journal clubs and case presentations, must be evaluated by all attendees as well. Please review the assessment criteria for each assignment.

The evaluation strategy is outlined for each learning experience. The categories of required documented evaluation are listed below.

1. **Preceptor’s Evaluation of the Resident (Summative)**
   The preceptor evaluates the resident’s attainment of the learning goals and objectives for the rotation. This evaluation will determine when a resident has achieved an objective and describe the behaviors, attributes and skills of the resident during and upon completion of the rotation. In addition, this evaluation is used to improve the quality of future learning and practice experiences for the resident.

2. **Resident’s Evaluation of the Learning Experience (Summative)**
   The resident must evaluate the quality of each learning experience, including the preceptor’s performance as a teacher and mentor. This evaluation provides useful information to the program director regarding the strengths and weaknesses of the rotations, preceptors, and residency program.

3. **Resident’s Self-Evaluation**
   The resident must evaluate their own performance 1) at the end of each rotation, 2) after completion of each assignment and/or 3) at the end of each quarter.

4. **Resident’s Evaluation of the Preceptor**
   In addition evaluating the experience, the resident will evaluate the preceptor at the end of each rotation or at the end of each quarter. Please provide timely and constructive feedback to allow the preceptor to improve their performance to best assist in your learning.

5. **Development Plan**
   The program director, site coordinator, and the resident will develop a plan each quarter following the review of all rotation evaluations and completion of all quarterly evaluations. The resident’s Development Plan is updated based on the resident and program director assessment of the resident’s strengths, weaknesses, interests, needs and career plans and performance on rotations, projects, and presentations. A final evaluation of the resident and program is completed at the end of the year and added to the Development Plan.

6. **Snapshots or Formative Evaluations**
   Snapshots may be utilized to enhance the quality of a resident’s self-evaluation. Formative evaluations are scheduled snapshots that were pre-selected to provide feedback to residents on a specific patient care activities in which a typical resident will benefit from specific feedback on their performance.
All evaluations should culminate in a face-to-face discussion between the resident and preceptor within one week of completion. It is important to complete the evaluations in a timely fashion to assure that the information contained within the evaluation is current, accurate, and timely. All evaluations must be reviewed, signed, and dated by the resident, preceptor, and program director. Completed evaluations must be returned to the Residency Program Director. If the completion of an evaluation must be delayed to allow completion of requirements or schedule problems, please communicate this to the program director.

DOCUMENTATION OF PATIENT CARE

Residents will document patient care interventions/activities using an online system called Quantifi®. This system is the same that STLCOP faculty and students use to document interventions. It was developed to be a quick way to document activities, taking just seconds to complete and accessible from the web and mobile devices.

Patient care activities should be documented in order for us to assess number and quality of patient care activities and your impact on your practice sites. It will also allow us to see the level of complexity of your involvement with patients. We will be able to measure your outcomes and use this for your personal evaluations. It will be useful for our accreditation purposes as well.

To facilitate your smooth implementation and use of Quantifi®, the following supporting materials have been created:

1. User Instructions (please see attached comprehensive guide to all users in the appendices of this document)
2. Brief (~17 minutes) demonstration video via Panopto, available at the following link: http://streaming.stlcop.edu/Panopto/Pages/Viewer/Default.aspx?id=f203e7ae-bfc8-46f8-915c-a2515c8ac965.

Please review both of these materials before using Quantifi®. They should contain all of the information you need to get started.

A few notes:
- You will be emailed your user ID and password from STLCOP.
- This system is not replacing documentation of patient care at your site. It is not patient specific or searchable. This system does not document programmatic or patient outcomes.
- No patient identifiable information or provider (physician/nurse) information should be included.
- You will need to choose a Service Name. In order to assist with our assessment if a practice site, please choose the appropriate practice site AND LED the activity is connected to.

<table>
<thead>
<tr>
<th>Site</th>
<th>Service Name</th>
<th>Primary Affiliated LED</th>
</tr>
</thead>
<tbody>
<tr>
<td>L&amp;S</td>
<td>L&amp;S Pharmacy Resident STAFF</td>
<td>Patient Centered Dispensing</td>
</tr>
<tr>
<td></td>
<td>L&amp;S Pharmacy Resident PT CARE</td>
<td>Patient Care: Primary Care</td>
</tr>
<tr>
<td></td>
<td>L&amp;S Pharmacy Resident OUTREACH</td>
<td>Outreach &amp; Advocacy</td>
</tr>
<tr>
<td></td>
<td>L&amp;S Pharmacy Resident SPECIALTY</td>
<td>Patient Care: Specialty</td>
</tr>
<tr>
<td></td>
<td>L&amp;S Pharmacy Resident MGMT</td>
<td>Leadership &amp; Management</td>
</tr>
<tr>
<td>Pharmax</td>
<td>Pharmax Resident STAFF</td>
<td>Patient Centered Dispensing</td>
</tr>
<tr>
<td></td>
<td>Pharmax Resident PT CARE</td>
<td>Patient Care: Primary Care</td>
</tr>
<tr>
<td></td>
<td>Pharmax Resident OUTREACH</td>
<td>Outreach &amp; Advocacy</td>
</tr>
<tr>
<td></td>
<td>Pharmax Resident SPECIALTY</td>
<td>Patient Care: Specialty</td>
</tr>
<tr>
<td></td>
<td>Pharmax Resident MGMT</td>
<td>Leadership &amp; Management</td>
</tr>
<tr>
<td>Schnucks</td>
<td>Schnucks Specialty #304 BRENTW</td>
<td>Patient Centered Dispensing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Care: Primary Care</td>
</tr>
<tr>
<td></td>
<td>Schnucks Specialty #327 LINDELL</td>
<td>Patient Care: Specialty</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient Care: Primary Care</td>
</tr>
</tbody>
</table>
In addition to this documentation, your sites will have patient specific documentation requirements in place for patient interventions. This is an area of known improvement for many sites. System improvements could include developing quicker, easier ways to document such as templates, or more comprehensive or searchable documentation ability. Another example is identifying ways to integrate the documentation into the workflow of the system. Sites are working on improving documentation and the Resident should be an active part of this process.
Human Resources Information

GENERAL

- It is understood that the resident is to adhere to their employer policy and procedures at all times.
- The College maintains a Google site that includes policies, forms, a calendar, and announcements. It is located at https://sites.google.com/site/stlcopresidency/. This includes information for both employed and non-employed residents.
- Additional college policies and procedures are available online under “MYSTLCOP” website. Some are under the “Policy Library” and “Handbooks & Guidelines.” The STLCOP Faculty and Staff Handbook is available on MYSTLCOP→ Handbooks & Guidelines.
- All residents are given the appointment of Instructor, Pharmacy Practice at STLCOP.
- This is a one year appointment generally beginning July 1 and ending June 30 of the following year. You will report to the Residency Program Director (RPD) and the site coordinator.
- Residents are evaluated according to ASHP/APhA guidelines.
- Graduation of the residency is dependent on completion educational goals listed in this Residency Handbook. Upon completion of the residency, you will receive a certificate of completion.
- You are eligible for benefits such as healthcare and paid time off from your employer according to their policies. Please notify the Residency Program Director in addition to the Site Coordinator of any time away from the site in advance.
- The resident must complete and pass all pre-employment screenings and record keeping (e.g. copy of license or immunizations) as defined by their employer.
- Residents should reasonably expect to work approximately 55 hours per week. This may include some evening or weekend shifts or health fairs.

DUTY HOUR POLICY

Purpose:
St. Louis College of Pharmacy Residency Programs are committed to both quality resident training and patient care. As described in the ASHP policy, it is the responsibility of residents, preceptors and program directors that residents are fit to provide patient care services in a way that promotes patient safety. These policies and procedures will help ensure that the resident work schedule is in compliance with ASHP Work Duty Hour policies.

General
It should be understood that the residency is a full-time position and should be considered the resident’s primary work responsibility. The resident must abide by current duty hour standards set by ASHP. (See appendix).

Residents should adhere to policies and procedures established by their employer and each practice site during all learning experiences. The employer will review policies with the resident during their orientation. Similarly, residents with learning experiences at off-site locations should be oriented to relevant policies by their preceptor. For residents directly employed by St. Louis College of Pharmacy a copy of the STLCOP Faculty and Staff Handbook can be found on the MYSTLCOP page of the College’s website.

Learning Experiences should be structured to be in compliance with the duty hour policy. For situations in which the resident may have responsibilities to multiple learning experiences concurrently, it is the Residency...
Program Director’s responsibility to make sure that the resident’s schedule does not violate this policy. For example, if a resident has pharmacy staffing responsibilities in the evening or on weekends, accommodations may need to be made with their rotation to ensure adequate time off.

Residents are required to self-monitor duty hours. Residency Program Directors will identify one of the following processes for tracking duty hours. This may include:

1. **Completing PharmAcademic calculation of duty hours**
   The resident needs to track the hours worked at each practice site or at the College. At the end of each month, the resident will complete the PharmAcademic evaluation on duty hours. Each question should be answered and work hours reported.

2. **Documentation of hours via OpenTimeClock**
   More information about this is available in the Google documents.

Residents will notify their Residency Program Director in writing immediately if they are approaching maximum duty hours allowed within a week (within 10 hours of limits) or if they identify a scheduling issue that may conflict with the duty hour policy.

**Work outside the scope of Residency Learning Experiences**
To promote the well-being of the resident and the patients they serve, “moonlighting” or working outside the scope of the residency program learning experiences is prohibited throughout the residency program. This applies to additional work at the residency learning site or outside sites. Residents who are determined to be working outside the scope of the residency program may be subject to dismissal from the program.

Updated July, 2014

**RESIDENT OBLIGATIONS**
In order to be successful, the RPD, site coordinator, preceptors, and residents must work together and communicate effectively. The residency program will follow guidelines set forth by ASHP/APhA, and be in compliance with ASHP Regulations on Accreditation of Pharmacy Residencies. The following are obligations the resident has to the program.

- The resident’s primary professional commitment is to the residency program. The resident will adhere to the values and mission of STLCOP and the site.
- The resident will complete the educational goals and objectives established by the program.
- The resident will ask for verbal and written feedback from preceptors.
- The resident will make active use of constructive feedback from preceptors.
- The resident will review this handbook, any additional handbooks/policies from the employer, as well as accreditation standards.

**PHARMACY LICENSURE**
Pharmacist faculty who interact with students in pharmacy practice settings in either clinical clerkship or externship positions are required to be licensed in either Missouri and/or Illinois, depending on their practice site. Preceptors and adjunct faculty in the externship program are required to have a current pharmacist license and in Missouri, they also must have a current internship certificate for their practice site.

Pharmacy Residents are expected to obtain a Missouri Pharmacy License with a Medication Therapy (MT) Services certificate by July 1. If not attainable, then licensure is expected by August 1. In certain cases, the
deadline can be extended to August 31 or 90 days from eligibility, depending on your employer. The resident will be subject to termination unless documented, extenuating circumstances are presented to the residency program director and site coordinator. A separate application for a certificate of medication therapeutic plan authority must be submitted to the Missouri Board of Pharmacy. Individuals licensed in another state may obtain a temporary pharmacist license for practicing pharmacy in conjunction with their post-graduate residency training program.

If a resident does not have a Missouri Pharmacy license prior to the start of the residency on July 1, some practice sites may require that the resident obtain a pharmacy intern license while awaiting for full pharmacist licensure. The resident is expected to notify the residency program director when their licensure examination date is scheduled and forward a copy of their license as soon as possible.

Specific questions related to exam dates and reciprocity requirements should be addressed to the Missouri State Board of Pharmacy or the Department of Registration and Education in Illinois.

Excerpt from St. Louis College of Pharmacy Employee Handbook
Page 77

Available at: https://my.stlcop.edu/hr/Documents/toemployee/employeehandbook.pdf
Updated: March 26, 2014

WORKSPACE AND RESOURCES

REFER TO THE GOOGLE SITE FOR MORE INFORMATION!

- Workspace will be provided at the site for each resident.
- While at STLCOP, the following work spaces are available:
  - Resident Office on the third floor of ARB, room 331. Contains a desktop computer for printing and use of programs.
  - Other conference rooms or classrooms at STLCOP may also be reserved in advance. Refer to the Resident Google site.
- Residents have access to relevant textbooks and online resources, in addition to library privileges at STLCOP and Washington University.
- STLCOP email accounts and access to all library resources will be provided to residents.

PROFESSIONAL MEETING ATTENDANCE POLICIES

- It is an expectation that each resident attend one major pharmacy meeting every year. Up to $1500 is budgeted toward travel to professional meetings from the St. Louis College of Pharmacy.
  - The primary expectation is to attend the American Pharmacists Association Annual Meeting (March or April). The purpose is to present your research project, recruit, attain continuing education and participate in professional development, and network with other pharmacists. There will be required attendance to some events at this meeting.
  - American Society of Health-System Pharmacy Midyear Clinical Meeting occurs in December of each year. Attendance to this meeting will be based on an “as needed basis”. The purpose of attendance is primarily recruitment for the residency. During this meeting residents are required to participate in recruitment activities and are
encouraged to attend professional development sessions. A limited reimbursement may be available depending on the budget.

- Attendance at additional professional meetings will be considered on a case-by-case basis. Requests should include an estimated budget, rationale/justification for attendance, and should be formally submitted to the program director well in advance of the meeting to allow for early bird registration discounts (if applicable). No additional funds are guaranteed from STLCOP or the sites.

- Residents travel to meetings should allow for the minimal time missed from the site while allowing the needed attendance at the meeting and appropriate travel time. Discuss with the RPD best times for arrival and departure from the meeting prior to making arrangements for travel.

- At the beginning of the residency, residents must fill out the Pharmacy Practice Professional Travel Planning form.

- Prior to travel, STLCOP-employed residents must fill out the absence request form.

- Upon return, residents will submit proof of continuing education attended as well as expense report to their RPD within two weeks.

- Residents may be asked to review items they learned at the meeting with colleagues.

**PAID TIME OFF**

- The resident is entitled to paid time off as set forth in each employer's employment and benefit policies or procedures. For the residency, these additional stipulations apply:
  - Only up to five vacation days will be approved during the final month of the residency year.
  - Vacation days must be arranged through and approved by your site coordinator and residency program director a minimum of two weeks in advance of the date.
  - In the absence of special circumstances, no more than two consecutive workdays will be approved.
  - In the event of illness, please contact your site coordinator and/or program director as early as possible to arrange for coverage of your responsibilities.

**STLCOP employees:**
- Ten days of paid vacation time are provided during your residency year. Five of these days are reserved for professional interviews.

**EXTENDED ABSENCE LEAVE & FAMILY MEDICAL LEAVE POLICY**

The St Louis College of Pharmacy recognizes that employees occasionally need to take time away from work to care for important family and medical needs, for personal reasons, or for military service. To meet these needs in a manner beneficial to the employee, their families, and St Louis College of Pharmacy, employees may consider several types of leave plans.

Any pharmacy resident request for extended absence will be individually assessed by the residency program director, Associate Dean for Post-Graduate Education, and a representative from any institution which serves as the primary employer of the pharmacy resident. More than 60 calendar days of leave of absence may result in dismissal of the pharmacy resident from the program. Missed time less than or equal to 60 calendar days may be rescheduled or extended in order to ensure satisfactory completion of the pharmacy residency program. The residency year may be adjusted to accommodate resident needs (ex. December used as rotation month or extension into the following summer months beyond the June 30th date of completion). Missed work must be rescheduled or extended when a preceptor is readily available for precepting (Monday – Friday).
Failure to comply may result in dismissal of the pharmacy resident from the program as determined by the residency program director (RPD), Associate Dean for Post-Graduate Education, and a representative from any institution which serves as the primary employer of the pharmacy resident. Any resident that is dismissed from the program will forfeit the completion certificate for the residency program. For additional information, contact Human Resources and refer to the residency handbook regarding Resident Dismissal. The pharmacy resident is not eligible for Family Medical Leave Act (FMLA) benefits if he/she has been employed by the St Louis College of Pharmacy for less than 12 months.

If the pharmacy resident qualifies for FMLA, the resident must comply with the following policy of the St Louis College of Pharmacy Faculty and Staff Handbook.

Family and Medical Leave Act (FMLA)

1. **Basic FMLA Leave and Active Duty Leave:** Provided certain requirements are met, those employees who have been employed for at least 12 months and for at least 1,250 hours during the previous 12 month period may be entitled to up to 12 weeks of leave during a rolling twelve month period measured backward from the date leave first begins, under the following circumstances:
   i. The birth of a child and to care for such child or placement for adoption or foster care of a child;
   ii. To care for an immediate family member (spouse, child under 18 years old or 18 or over that is incapable of self-care, or parent) with a serious health condition;
   iii. Because of a serious health condition which renders the employee unable to work; or
   iv. Because of any qualifying exigency arising out of the fact that your spouse, son (of any age), daughter (of any age), or parent, defined as a covered military member, is on active duty (or has been notified of an impending call or order to active duty) in the National Guard or Reserves or is a retired member of Armed Forces or Reserves and has been notified of an impending call or order to active duty in support of a contingency operation. Please note certain exigencies are limited to a certain number of days of leave.

2. **Military Caregiver Leave:** An employee also may take Military Caregiver Leave to care for a spouse, son (of any age), daughter (of any age), parent or next of kin (as defined) who is a current member of the Armed Forces, including the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. A covered service member incurs a serious illness or injury for purposes of this paragraph when he or she is medically unfit to perform the duties of his or her office, grade, rank or rating.

Eligible employees are entitled to a total of 26 weeks of unpaid Military Caregiver Leave during a single 12-month period. This single 12-month period begins on the first day an eligible employee takes Military Caregiver Leave and ends 12 months after that date.

The leave entitlement described in this Section applies on a per-covered service member, per injury basis. However, no more than 26 weeks of leave may be taken within a single 12-month period by any covered employee. Even in circumstances where an employee takes other leave covered by the federal FMLA under numbers 1-4 in the Basic FMLA Leave and Active Duty Leave section above, the combined leave shall not exceed 26 weeks during that 12-month period.

3. **Definitions:** A “serious health condition” referenced in numbers (2) and (3) of the Basic FMLA Leave and Active Duty Leave section above means an illness, injury, impairment, or physical or mental condition that involves:
   i. In-patient care (i.e., an overnight stay) in a hospital or other medical care facility (including any period of incapacity or any subsequent treatment in connection with such in-patient care);
   ii. Period of incapacity of more than 3 consecutive full calendar days, and any subsequent treatment or period of incapacity relating to the same condition that also involves (i) treatment 2 or more times by a health care provider or under the supervisor of a health care provider within 30 days of the start of the incapacity, or (ii) treatment by a health care provider on at least one (1) occasion within 7 days of the start of the incapacity which results in a regimen of continuing treatment under the supervision of a health care provider;
iii. Any period of incapacity due to pregnancy, or for prenatal care;
iv. Any period of incapacity due to a chronic serious health condition requiring periodic visits of at least twice a year for treatment by a health care provider;
v. A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective, during which the employee (or family member) must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider; or
vi. Any period of absence to receive multiple treatments by a health care provider or under the supervision of a health care provider, either for restorative surgery after an accident or other injury, or for a condition that will likely result in a period of incapacity of more than 3 consecutive calendar days in the absence of medical intervention or treatment.

A “qualifying exigency” referenced in number (4) of the Basic FMLA and Active Duty Leave section above refers to the following circumstances:

i. Short-term deployment: to address issues arising when the notification of a call or order to active duty is seven (7) days or less;
ii. Military events and related activities: to attend official military events or family assistance programs or briefings;
iii. Childcare and school activities: for qualifying childcare and school related reasons for a child, legal ward or stepchild of a covered military member;
iv. Financial and legal arrangements: to make or update financial or legal affairs to address the absence of a covered military member;
v. Counseling: to attend counseling provided by someone other than a health care provider for oneself, for the covered military member, or child, legal ward, or stepchild of the covered military member;
vi. Rest and recuperation: to spend up to five (5) days for each period in which a covered military member is on a short-term rest leave period during a period of deployment;
vii. Post-deployment activities: to attend official ceremonies or programs sponsored by the military for up to 90 days after a covered military member’s active duty terminates or to address issues arising from the death of a covered military member while on active duty;
viii. Additional activities: for other events where the College and the employee agree on the time and duration of the leave.

4. When spouses work together: Eligible employees who are husband and wife are limited to a combined total of 12 weeks of leave during any 12 month period, if the leave is taken (1) for birth of a child; (2) for placement and care of a child; or (3) to care for a parent (but not “parent-in-law”) with a serious health condition. Where the husband and wife both have used a portion of the 12 week entitlement for one of the above purposes, each are entitled to the difference between the amount he or she has taken individually and 12 weeks to care for a child with a serious health condition or to treat their own serious health condition.

5. Notice of need for FMLA Leave: If the leave is foreseeable (e.g., birth or placement, planned medical care, leave due to active duty of immediate family member), the employee must provide at least 30 days advance notice to their immediate supervisor, who will advise the Human Resources Department. If circumstances prevent providing the 30 days advance notice, then the employee should provide as much notice as possible (ordinarily the same or next business day). If an employee fails to give the required notice for foreseeable leave with no reasonable excuse, the employee may be denied the taking of the leave until the employee provides adequate notice of the need for the leave. Employees must make every reasonable effort to schedule medical treatments so as not to disrupt the ongoing operations of the department.

6. Intermittent FMLA Leave: Intermittent leave also may be available depending upon an employee’s serious health condition or an employee’s immediate family member’s serious health condition. Intermittent or reduced schedule leave for the birth or placement of a child for adoption or foster care may only be taken with approval from Human Resources. Military Caregiver Leave may be taken intermittently or on a reduced leave schedule when medically necessary. Employees taking intermittent
leave must follow the College’s standard call-in procedures absent unusual circumstance. Employees must specify if the reason for the call-in is related to an FMLA intermittent leave as opposed to a non-FMLA illness. The employee must, however, make a reasonable effort to schedule medical treatment so as not to disrupt unduly College operations. Further, if the need for leave is foreseeable based on planned medical treatment, the employer reserves the right to transfer the affected employee temporarily to an alternate position with equivalent pay and benefits for which the employee is qualified, if the transfer better accommodates the requested leave.

7. **Documentation supporting FMLA leave:** Your reason for the leave must be covered under FMLA and you must provide a completed FMLA Certification Form supporting the need for the leave for any event other than birth of a child. Human Resources will provide employees with the appropriate form to certify a serious health condition. A request for reasonable documentation of family relationship verifying the legitimacy of FMLA Leave may also be required. The employee will have 15 days in which to return a completed Certification form following receipt of the form from the College. If the employee fails to provide timely certification after being required to do so, the employee may be denied the taking of the leave under FMLA. If the Certification form is incomplete or insufficient, an employee will be given written notification of the information needed and will have 7 days after receiving such written notice to provide the necessary information. If the form is complete but unclear the College reserves the right to have Human Resources contact the health care provider with the employee’s permission and release. If there is reason to doubt the validity of the medical certification, a second opinion, at the expense of the College, related to the health condition may be required. If the original certification and second opinion differ, a third opinion, at the expense of the College, may be required. The opinion of the third health care provider, which the College and employee jointly select, will be the final and binding decision. A request for Active Duty Leave must be supported by the Certification of Qualifying Exigency for Military Family Leave form as well as appropriate documentation, including the covered military member’s active duty orders. A request for military Caregiver leave must be supported by the Certification for Serious Injury or Illness of Covered Service member form as well as any necessary supporting documentation.

8. **Recertification:** Under certain circumstances as provided by the law, including (but not limited to) situations in which the need or nature of the approved leave changes, the College may, in its sole discretion, require recertification of your serious health condition. The Company may also request recertification every year in which FMLA Leave is taken for any serious health condition that lasts longer than 1 year. In these situations you will have 15 days in which to provide, at your expense, a completed recertification form.

9. **Substitution of paid leave:** Employees are required to substitute and exhaust sick pay and vacation pay for leave requested. Such substituted paid time will run concurrently with, and be applied against, the 12 week maximum. Use of sick and vacation time will follow the established rules for each benefit. For birth of a child sick leave may only be used for the period of disability associated with the birth with the remainder of FMLA using other types of paid time off. Employees do not continue to accrue time off while on leave. Holidays falling during an entire week of FMLA leave will be counted towards FMLA leave. For a partial week of leave the holiday will not count as FMLA leave. After paid leave finishes running the remainder of the leave will be unpaid. If an employee takes paid sick leave for a condition that progresses into a serious health condition the College may designate all or some portion of related leave taken under this policy as FMLA, to the extent that the earlier leave meets the necessary qualifications.

10. **Benefits under FMLA leave:** During the 12 week maximum leave period, coverage under group health, dental, and voluntary life insurance plans, if any, will be maintained at the level and under the conditions coverage would have been provided had leave not been taken. Employees will be required to continue to pay their portion of any applicable premiums as if they had not taken leave and failure to do so may result in loss of coverage pursuant to the law. See Human Resources to make payment arrangements. If the employee chooses not to return to work for reasons other than a continued serious health condition of the employee or the employee’s family member or a circumstance beyond the employee’s control, the College will require the employee to reimburse the College the amount it paid for the employee’s health insurance premium during the leave period.
11. **Return to Work:** As a condition of returning to work from a leave granted pursuant to (3) above, the employee must timely present a certification from his/her health care provider that the employee is able to perform the essential functions of his or her position. Restoration will be denied until the certification is presented. An employee returning from leave under this Policy, who has complied with its terms, generally will be restored to the same (or equivalent) position the employee held prior to leave. A returning employee does not, however, have a greater right to restoration or other benefits than if the employee had been continuously employed during the leave period. Employees are to notify their supervisor and/or Human Resources of their intent to return to work at least two weeks prior to the anticipated date of return.

Date: April 15, 2014

**PROFESSIONALISM**

The St. Louis College of Pharmacy is committed to the development and training of pharmacy residents. It is expected that those participating in the administration or completion of a pharmacy residency program associated with the STLCOP will conduct themselves in a professional, collegial, and respectful manner at all times, working together to promote the advancement of pharmacy practice, to encourage the development of residents, preceptors, students, directors, and other healthcare providers, and to provide patient-centered care.

Within the challenging environment of pharmacy practice and pharmacy residency training it would be anticipated that conflicts between involved persons may arise. It is expected that conflicts will be approached and resolved in a professional manner. This policy defines procedures and guidelines to be utilized in the case of conflicts that cannot be or are not resolved between program administrators and participants. Additionally, this policy outlines the steps to be taken if the need for formalized remediation or discipline of a pharmacy resident is required.

**SOCIAL MEDIA**

Residents are expected to follow technology and electronic information acceptable use policies within each organization.

In addition to those policies, please abide by the following to maintain integrity of the residency and the site.

- Refrain from posting any information regarding patients or patient interactions that is identifiable in any way by you or co-workers.
- Refrain from posting information about STLCOP or sites that could negatively impact the college, the companies, other colleagues, or the residency. Rather, if there are issues that need resolving, please bring to the attention of the Site Coordinator or the RPD.
RESIDENT GRIEVANCE / DISCIPLINARY POLICY & PROCEDURES

The St. Louis College of Pharmacy, in accordance with its mission to “make a difference in student learning, patient care, and pharmacy education,” is committed to the development and training of pharmacy residents. Those participating in the administration or completion of a pharmacy residency program associated with the St. Louis College of Pharmacy are expected to conduct themselves in a professional, collegial, and respectful manner at all times, working together to promote the advancement of pharmacy practice, to encourage the development of residents, preceptors, students, program directors, and other healthcare providers, and to provide patient-centered pharmaceutical care.

Within the challenging environment of pharmacy practice and pharmacy residency training, conflicts between involved persons may arise. It is expected that conflicts will be approached and resolved in a professional manner. This policy defines procedures and guidelines to be utilized in the case of conflicts that cannot be or are not resolved between program administrators and residents. Additionally, this policy outlines the steps to be taken if the need for formalized remediation or discipline of a pharmacy resident is required.

The Residency Program Director will include the respective site coordinator in each step of the Resident Grievance/Disciplinary Policy and Procedures.

I. PROCEDURE FOR RESIDENT COMPLAINTS

If a pharmacy resident has a particular complaint while completing a St. Louis College of Pharmacy training program, he/she shall first attempt to resolve it on his/her own through consultation with a preceptor or his/her Residency Program Director. If the issue is not resolved with a preceptor, then the resident should discuss the issue with the Residency Program Director. If the conflict remains unresolved, the resident may submit the complaint, in writing, to the Associate Dean for Post-Graduate Education. If the complaint cannot be adjudicated through the efforts of the Associate Dean for Post-Graduate Education, an ad-hoc committee will be appointed by the Associate Dean to hear the complaint. The committee will consist of the Associate Dean for Post-Graduate Education (chair), a program director, two preceptors and a resident from different College residency programs. With the exception of the Associate Dean for Post-Graduate Education, members of this committee shall not have been involved in previous attempts to adjudicate the complaint. The decision and/or resolution of the appointed committee regarding the complaint shall be final.

II. DISCIPLINARY ACTIONS AGAINST RESIDENTS

Pharmacy residents are expected to place the highest priority on the completion of residency requirements, the achievement of residency goals, and the provision of patient care. Furthermore, it is expected that residents will strive to continuously improve their performance and clinical, professional, and educational skills through completion of the program. In accordance with ASHP accreditation requirements, pharmacy residents will be assessed regularly by preceptors, program directors, and other members of the pharmacy and healthcare community. Each Residency Program Director is responsible for creating and maintaining a method, consistent with accreditation standards, for assessing and documenting the performance and progress of pharmacy residents. This shall include a procedure for providing written progress reports and evaluations of residents to facilitate the improvement and development of their skills and abilities.

If a pharmacy resident fails to show satisfactory progress or performance in any clinical, professional, or educational requirement of the residency program, a variety of actions may be taken by the program director. A structured remediation process for pharmacy residents may include one of the following actions: resident placed on OBSERVATIONAL STATUS, PROBATION, SUSPENSION, with the potential for a resident to be DISMISSED from the program. Some situations may necessitate a deviation from this standard, and it
may not be necessary or proper to move through all levels of the policy for a resident to be placed on probation, to be suspended, or dismissed from the program.

A. OBSERVATIONAL STATUS

Observational status is the first step that may be utilized for structured remediation of a pharmacy resident. If a pharmacy resident's clinical or educational progress and/or performance are found to be unsatisfactory, the Residency Program Director will meet with the resident as soon as possible. Together, the resident and Residency Program Director will outline, in writing, the following: noted areas of insufficiency, a detailed plan for improvement, a plan for reassessment, and the timeframe in which this is to be completed. Copies of the plan will be provided to the Associate Dean for Post-Graduate Education. If the pharmacy resident fails to achieve adequate improvement/progress over the specified timeframe, the resident may be placed on probation.

B. PROBATION

1. A pharmacy resident may be placed on probation if his/her professional, clinical, or educational progress or development is unsatisfactory and continuation of the program or receipt of certificate is at risk. If a pharmacy resident fails to meet the standards of progression for the training program, the Residency Program Director, may recommend probationary status. This must be approved by the Associate Dean for Post-Graduate Education. The Associate Dean will notify the Dean of Pharmacy and Director of Human Resources.

2. It is not necessary for a resident to be placed on observational status prior to being placed on probation; a resident may be directly placed on probation at any time for more serious performance concerns. The assignment of probationary status is not subject to appeal by the resident.

3. Details of the probationary status and specific reasons for probation implementation will be provided to the resident in writing, delivered by certified mail, return receipt requested, at his/her residence, or hand-delivered with written acknowledgment of receipt to the resident. In addition to providing written notification, the Residency Program Director must also discuss this decision with the resident at the earliest possible time. Together, the resident and the Residency Program Director will outline, in writing, the following: noted areas of deficiency, a detailed plan for improvement, a plan for reassessment, and the timeframe in which this is to be completed. The documentation will clearly detail specific performance related areas of concern and/or deficiency.

4. As noted above, the Residency Program Director shall provide a specific, detailed plan for reassessment. This plan shall include a specific timeline for activities related to remediation and reassessment. In general, at least 30 calendar days will be allowed for the resident to improve their performance related to the specified areas of insufficiency. Probationary status may be assigned for a shorter or longer period with the approval of the Associate Dean for Post-Graduate Education.

5. At the conclusion of the probationary period, the Residency Program Director will complete a reassessment of the resident regarding the targeted areas for improvement. If the reassessment determines that the resident has not achieved satisfactory progress toward the correction of the identified deficiencies, the resident may be recommended for dismissal from the program as detailed in section D below. Dismissal from the program is subject to appeal; appeal of dismissal must follow the procedures as detailed in section E below.
6. If, at the specified time of reassessment, the Residency Program Director is satisfied with the progress and improvement of the resident in the areas targeted for remediation and any other areas of concern that may have arisen during the probationary period, the resident will be notified in writing of the repealing of probationary status.

C. SUSPENSION

1. The Residency Program Director may place a resident on suspension with the approval of the Associate Dean for Post-Graduate Education. Situations that may result in suspension include, but are not limited to, the allegation of a serious professional charge against the resident, concern that a resident’s performance has been compromised, or actions by a resident which result (or may result) in an increased risk to patients. The Associate Dean will notify the Dean of Pharmacy and the Director of Human Resources.

2. The suspension may be with or without pay, dependent upon the discretion of the Associate Dean for Post-Graduate Education, in consultation with the Dean of Pharmacy and Director of Human Resources. Suspension with pay is not subject to appeal. Suspension without pay is subject to appeal through the process detailed in section E below.

3. Notification of suspension will be provided to the resident in writing, delivered by certified mail, return receipt requested, at his/her residence, or hand delivered with written acknowledgment of receipt to the resident. The Program Director and Associate Dean for Post-Graduate Education shall confer with the resident regarding the suspension as soon as practical.

4. An investigation of specified concerns, allegations, or actions will be initiated within 5 working days. The investigation team will include a Residency Program Director, the Associate Dean for Post-Graduate Education, and another residency preceptor or program director. The determination of reinstatement or dismissal of the resident will be made within 30 calendar days. This will allow the investigation team time to fully evaluate the concerns, allegations, or actions pertinent to the situation and recommend appropriate action. The suspension period may be extended beyond 30 days with approval of the Dean of Pharmacy if more time is needed to complete an appropriate investigation.

D. DISMISSAL

1. Upon recommendation of the Residency Program Director and the Associate Dean for Post-Graduate Education, the Dean of Pharmacy may dismiss a resident from a pharmacy residency program for unsatisfactory performance or conduct. Potential grounds for dismissal include, but are not limited to:

   a. Illegal, unethical, or unprofessional conduct;
   b. Excessive tardiness/absenteeism;
   c. Job abandonment (3 or more days absent from program without notice given to the Residency Program Director);
   d. Resident performance that is not satisfactorily progressing past a newly graduated pharmacist level, or actions that results in an increased risk to patients; performance which presents a serious compromise to acceptable standards of patient care or jeopardizes patient welfare.
2. The recommendation for dismissal shall be submitted to the Dean of Pharmacy in writing by the Associate Dean for Post-Graduate Education. This documentation shall detail the specific areas of performance, conduct, or concerns that are the grounds for the recommendation of dismissal.

3. Dismissal related to job abandonment will be considered equivalent to resignation and is not subject to appeal. Dismissal related to unsatisfactory performance or conduct is subject to resident appeal as detailed in section E below.

4. The Dean of Pharmacy will send written notification of dismissal to the following:
   a. Pharmacy Resident (certified mail, return receipt requested or hand-delivered with written acknowledgment of receipt/delivery)
   b. Residency Program Director
   c. Associate Dean for Post-Graduate Education
   d. Department Chair of Pharmacy Practice
   e. The St. Louis College of Pharmacy Director of Human Resources

5. The resident will be notified of the dismissal and termination of employment. The termination date will be no sooner than the notification date. Employment related compensation and benefits will be paid out according to College policy.

6. If the dismissal is subject to appeal, appeal must be filed in writing within 5 working days of notification of dismissal as described in section E.

E. RIGHT TO APPEAL DISMISSAL

1. A pharmacy resident who has been dismissed from a St. Louis College of Pharmacy residency program shall be afforded the right to appeal dismissal (except when dismissal results from job abandonment; see section D 1, 3 above). Appeal of dismissal will be handled in a just fashion, being cognizant of rights of the pharmacy resident and the interests of the St. Louis College of Pharmacy and its affiliates.

2. A pharmacy resident wishing to appeal dismissal must submit the appeal, in writing, to the Dean of Pharmacy within 5 working days of dismissal notification. If an appeal of dismissal is not received by the Dean’s office within 5 days, the option of appeal will be considered waived and will amount to acceptance of dismissal by the resident.

3. An ad hoc Residency Dismissal Appeal Committee will be appointed by the Dean of Pharmacy. This committee shall consist of a current pharmacy resident, two preceptors of St. Louis College of Pharmacy residency programs, the Associate Dean for Post-Graduate Education, and the Chair of the Department of Pharmacy Practice. Members of this ad hoc committee shall not have been involved in previous disciplinary actions regarding the dismissed resident, except for the Associate Dean for Post-Graduate Education.

4. A time and place for the hearing of the appeal will be set by the Residency Dismissal Appeal Committee. It shall occur at the earliest reasonable date and within 10 days of the time of the submission of appeal.

5. Documentation pertaining to the contested dismissal will be provided to the appointed Residency Dismissal Appeal Committee members at least 5 business days prior to the dismissal appeal hearing. This documentation shall include all pharmacy residency related evaluations of the dismissed resident, documentation related to resident dismissal, and any other pertinent
information including the letter of appeal from the resident. At the resident’s request, this information will be made available to the resident for review and/or duplication.

6. The resident shall be allowed to introduce evidence that they believe to be pertinent to the dismissal proceedings. Any material the resident wishes to introduce must be provided to the Associate Dean for Post-Graduate Education at least 5 business days prior to the scheduled dismissal appeal hearing for inclusion in materials distributed to the Residency Dismissal Appeal Committee members.

7. The resident is afforded the right to appear in person with or without retained legal counsel at the dismissal appeal hearing. Failure of the resident to appear before the committee will result in dismissal of the appeal and the decision to dismiss will be upheld. Legal counsel shall participate in a strictly advisory role to the resident. St. Louis College of Pharmacy must be notified of the participation of legal counsel at least 5 business days prior to the dismissal appeal hearing. During the hearing, the resident will be offered the opportunity to address the committee, but this is not required.

8. St. Louis College of Pharmacy shall have the option of having legal counsel present during the hearing.

9. All materials, documentation, and evidence submitted or considered during the dismissal appeal hearing must be related to the reasons for dismissal from program and the resident’s appeal.

10. The Residency Dismissal Appeal Committee will confer and submit their findings and recommendations to the Dean of Pharmacy within 7 business days of the hearing. The Dean of Pharmacy will, within 7 days, review and disseminate the decision, in writing, to the following: the dismissed pharmacy resident (certified mail, return receipt requested, or hand delivered with written acknowledgement of receipt/delivery), the Chair of the Department of Pharmacy Practice, the Associate Dean for Post-Graduate Education, the Residency Program Director, the St. Louis College of Pharmacy President, and the Director of Human Resources.

11. All hearings, actions, and documentation related to the dismissal appeal process is considered confidential and shall not be discussed or disseminated outside of activities related to the appeals process as described above. All materials related to the appeals process shall be returned to the Associate Dean for Post-Graduate Education at the conclusion of the proceedings. These materials will be maintained as appropriate by the Associate Dean for Post-Graduate Education.

12. If the pharmacy resident wins the appeal, employment will be reinstated retroactive to the date of the original dismissal. The resident will be reinstated on a probationary status.

This policy/procedure must be completed, in entirety, prior to the pharmacy resident seeking appeal/mediation through any other forum.

Revised 3/12/14
Appendices
APPENDIX: ASHP DUTY HOUR POLICY

Residents, program directors and preceptors have the professional responsibility to ensure they are fit to provide services that promote patient safety. The RPD must ensure that there is not excessive reliance on residents to fulfill service obligations that do not contribute to the educational value of the residency program or that may compromise their fitness for duty and endanger patient safety.

Providing residents with a sound training program must be planned, scheduled and balanced with concerns for patient safety and resident’s well-being. Therefore, programs must comply with the following duty hour requirements:

I. Personal and Professional Responsibility for Patient Safety
   A. Residency program director must educate residents and preceptors concerning their professional responsibilities to be appropriately rested and fit for duty to provide services required by the patients and health care.
   B. Residency program directors must educate residents and preceptors to recognize signs of fatigue and sleep deprivation, and adopt processes to manage negative effects of fatigue and sleep deprivation to ensure safe patient care and successful learning.
   C. Residents and preceptors must accept personal and professional responsibility for patient care that supersedes self-interest. At times, it may be in the best interest of the patient to transition the care to another qualified, rested provider.
   D. If the program implements any type of on-call programs, there must be a written description that includes:
      • The level of supervision a resident will be provided based on the level of training and competency of the resident and the learning experiences expected during the on-call period
      • Identification of a backup system, if the resident needs assistance to complete the responsibilities required of the on-call program.
   E. The residency program director must ensure that residents participate in structured handoff processes when they complete their duty hours to facilitate information exchange to maintain continuity-of-care and patient safety.

II. Maximum Hours of Work per Week and Duty Free Times
   A. Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting. ASHP Duty Hours 3
   B. Moonlighting (internal or external) must not interfere with the ability of the resident to achieve the educational goals and objectives of the residency program.
      1. All moonlighting hours must be counted towards the 80-hour maximum weekly hour limit.
      2. Programs that allow moonlighting must have a documented structured process to monitor moonlighting that includes at a minimum:
         a. The type and number of moonlighting hours allowed by the program.
         b. A reporting mechanism for residents to inform the residency program directors of their moonlighting hours.
         c. A mechanism for evaluating residents overall performance that may affect residents’ judgment while on scheduled duty periods or impact their ability to achieve the educational goals and objectives of their residency program and provide safe patient care.
         d. A plan for what to do if residents’ participation in moonlighting affects their judgment while on scheduled duty hours.
C. Mandatory time free of duty: residents must have a minimum of one day in seven days free of duty (when averaged over four weeks). At-home call cannot be assigned on these free days.
D. Residents should have 10 hours free of duty between scheduled duty, and must have at a minimum 8 hours between scheduled duty periods.
E. If a program has a 24 hour in-house call program, residents must have at least 14 hours free of duty after the 24 hours of in-house duty.

III. Maximum Duty Period Length
A. Continuous duty periods of residents should not exceed 16 hours. The maximum allowable duty assignment must not exceed 24 hours even with built in strategic napping or other strategies to reduce fatigue and sleep deprivation, with an additional period of up to two hours permitted for transitions of care or educational activities.
B. In-House Call Programs
   1. Residents must not be scheduled for in-house call more frequently than every third night (when averaged over a four-week period).
   2. Programs that have in-house call programs with continuous duty hours beyond 16 hours and up to 24 hours must have a well-documented structured process that oversee these programs to ensure patient safety, resident well-being, and provides a supportive, educational environment. Well-documented, structured process must include at a minimum:
      a. How the program will support strategic napping or other strategies for fatigue and sleep deprivation management for continuous duty beyond 16 hours. ASHP Duty Hours 4
      b. A plan for monitoring and resolving issues that may arise with residents’ performance due to sleep deprivation or fatigue to ensure patient care and learning are not negatively affected.
C. At-Home or other Call Programs
   1. At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.
   2. Program directors must have a method for evaluating the impact on residents of the at home or other call program to ensure there is not a negative effect on patient care or residents’ learning due to sleep deprivation or serious fatigue.
   3. Program directors must define the level of supervision provided to residents during at home or other call.
   4. At-home or other call hours are not included in the 80 hours a week duty hour’s calculation, unless the resident is called into the hospital/organization.
   5. If a resident is called into the hospital/organization from at-home or other call program, the time spent in the hospital/organization by the resident must count towards the 80-hour maximum weekly hour limit.
   6. The frequency of at-home call must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. No at-home call can occur on the day free of duty.

Approved by the ASHP Commission on Credentialing on 3/4/2012
Approved by the ASHP Board of Directors on 4/13/12
St. Louis College of Pharmacy
Department of Pharmacy Practice
Professional Travel Planning Document
(Should be completed prior to early-bird meeting deadline)

Name: ___________________________ Date: ___________________________

Travel start date: ___________________________ Travel end date: ___________________________

Full days absent: ___________________________ Purpose of travel: ___________________________

Clinical site / student coverage: ___________________________

Lecture / discussion coverage: ___________________________

<table>
<thead>
<tr>
<th>Name of organization(s) or individual(s) visited</th>
<th>Destination (city, state)</th>
</tr>
</thead>
</table>

**Proposed Budget:**

<table>
<thead>
<tr>
<th></th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meeting Registration</td>
<td></td>
</tr>
<tr>
<td>- Must register during Early-bird period</td>
<td></td>
</tr>
<tr>
<td>Air Travel</td>
<td></td>
</tr>
<tr>
<td>- Must be purchased at least 4 weeks prior to travel</td>
<td></td>
</tr>
<tr>
<td>- Any flight &gt; $500 must be pre-approved by Division Director</td>
<td></td>
</tr>
<tr>
<td>Total Hotel Cost</td>
<td></td>
</tr>
<tr>
<td>- Roommate (If no roommate identified, Sandy Gore can assist)</td>
<td></td>
</tr>
<tr>
<td>$ X = $ (Cost per night X # of nights = Total Hotel Cost)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>

Prepared By: ___________________________ Date: ___________________________

Approved By: ___________________________ Date: ___________________________
Goal R4.1: Provide effective education and/or training.
Objective R4.1.2: (Applying) Use effective **presentation and teaching skills** to deliver education programs to targeted audiences including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.
Objective R4.1.3: (Applying) Develop effective **written communication skills** to provide educational information to multiple levels of learners including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.

<table>
<thead>
<tr>
<th>Type of Assessment (check one):</th>
<th>Expert □ Peer □ Student □</th>
<th>Date ____________________</th>
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</thead>
<tbody>
<tr>
<td>Name of Presenter _______________</td>
<td>Evaluator __________________</td>
<td></td>
</tr>
<tr>
<td>Presentation Title ______________</td>
<td>Journal Club # ____________</td>
<td></td>
</tr>
<tr>
<td>Evaluation Key: NI = Needs Improvement SP = Satisfactory Progress ACH = Achieved NA = Not applicable</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>EVALUATION CRITERIA</th>
<th>Comments / Evidence</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>Presenter addresses/includes the following components:</td>
<td></td>
</tr>
<tr>
<td>1. Current relevance of study/topic</td>
<td></td>
<td></td>
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<tr>
<td>2. Inclusion/comparison of other relevant studies and guidelines in background</td>
<td></td>
<td></td>
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<tr>
<td>3. Clinical relevance of study objective</td>
<td></td>
<td></td>
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<tr>
<td>4. Appropriate amount of background related to the pathophysiology, therapeutics, administration, etc.</td>
<td></td>
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<tr>
<td>5. Reputability of publication source including journal impact factor</td>
<td></td>
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</tr>
<tr>
<td><strong>Methodology</strong></td>
<td>Presenter conveys study methods in detail to:</td>
<td></td>
</tr>
<tr>
<td>1. Ensure audience understanding of the methodology</td>
<td></td>
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<tr>
<td>2. While excluding unimportant/extraneous elements</td>
<td></td>
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<tr>
<td>Presenter evaluates the study based on the following components:</td>
<td></td>
<td></td>
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<tr>
<td>1. Sound design/methodology to support conclusions</td>
<td></td>
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</tr>
<tr>
<td>2. Appropriateness of defined endpoints; methods used to study endpoints</td>
<td></td>
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<tr>
<td>3. Presence of selection bias and/or measurement bias</td>
<td></td>
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<tr>
<td>4. Presence/significance of confounders</td>
<td></td>
<td></td>
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<tr>
<td>5. Appropriateness of statistical methods used</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Results</strong></td>
<td>Presenter addresses/includes the following:</td>
<td></td>
</tr>
<tr>
<td>1. Accurate explanation of the results pertinent to the conclusions/objectives</td>
<td></td>
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<tr>
<td>2. Demographic analysis/applicability- external validity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Summary of primary and secondary endpoints</td>
<td></td>
<td></td>
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<tr>
<td>4. Potential for error</td>
<td></td>
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<tr>
<td>EVALUATION CRITERIA</td>
<td>Comments / Evidence</td>
<td>Evaluation</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td><strong>Discussion and Conclusions</strong></td>
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<tr>
<td>Presenter critically evaluates and thoroughly and</td>
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<tr>
<td>correctly critiques:</td>
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<tr>
<td>1. Limitations and strengths of the study</td>
<td></td>
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<tr>
<td>2. Statistical vs. clinical significance of findings</td>
<td></td>
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<tr>
<td>3. Presence of potential reporting bias</td>
<td></td>
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<tr>
<td>4. Internal and external validity</td>
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<tr>
<td>5. Degree to which author conclusions are supported</td>
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<tr>
<td>by results</td>
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<tr>
<td>6. Relevance in the context of other literature/guidelines</td>
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<tr>
<td>7. Overall effect on clinical practice/clinical relevance</td>
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<tr>
<td><strong>Clinical judgment</strong></td>
<td></td>
<td></td>
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<tr>
<td>1. Formulates specific and supported own conclusions</td>
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<tr>
<td>contrasted to author conclusions</td>
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<tr>
<td>2. Judgment is accurate and well-justified</td>
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<tr>
<td><strong>Communication skills</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates thorough understanding of the topic</td>
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<tr>
<td>2. Presents at an appropriate level for the audience,</td>
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<tr>
<td>clearly explaining difficult concepts</td>
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<td>3. Demonstrates ability to adapt if needed</td>
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<td>4. Makes smooth transitions between concepts</td>
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<tr>
<td>5. Clearly summarizes important information</td>
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<td>(organized and logical)</td>
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<td>6. Clearly explains difficult concepts</td>
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<tr>
<td>7. Allows adequate time for audience to follow-along</td>
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<td>when discussing tables, graphs, illustrations</td>
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<tr>
<td>8. Maintains audience interest</td>
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<tr>
<td>9. Maintains appropriate voice rate, quality, tone,</td>
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<td>and volume with articulation and engaging inflection</td>
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<td>10. Maintains appropriate eye contact with audience</td>
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<tr>
<td>11. Uses effective body language and expression</td>
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<tr>
<td>12. Uses correct pronunciation of terminology</td>
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<tr>
<td>13. Displays professionalism in communication style</td>
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<tr>
<td>14. Displays confidence and credibility</td>
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<tr>
<td>15. Responds to questions thoroughly and tactfully</td>
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<tr>
<td>16. Avoids distracting mannerisms during presentation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Handout</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Handout assists in understanding of the material</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and is not distracting from the presentation.</td>
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<td></td>
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<tr>
<td>2. Is referenced and includes list of references for</td>
<td></td>
<td></td>
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<tr>
<td>background or supplemental studies as well as original article</td>
<td></td>
<td></td>
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<tr>
<td>3. Has no or very limited typos</td>
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<tr>
<td>4. Effectively developed to support learning and be</td>
<td></td>
<td></td>
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<tr>
<td>used as a future reference</td>
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<tr>
<td><strong>Overall</strong></td>
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<tr>
<td><strong>Overall insights or Comments:</strong></td>
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</tbody>
</table>

Areas of strength (required):

Areas to focus on for enhancement/improvement (required):
Goal R4.1: Provide effective education and/or training.
Objective R4.1.2: (Applying) Use effective **presentation and teaching skills** to deliver education programs to targeted audiences including patients, caregivers, and members of the community; **health profession students; pharmacists;** and other health care professionals.
Objective R4.1.3: (Applying) Develop effective **written communication skills** to provide educational information to multiple levels of learners including patients, caregivers, and members of the community; **health profession students; pharmacists;** and other health care professionals.

**Directions:** Identify a case in which you are actively engaged in the therapeutic care plan. It is best if you have interviewed the patient and have access to some lab data if possible. Attempt to retrieve appropriate lab results from the patient or provider. Present the initial SOAP note and any subsequent follow up notes. Present an evidence-based and referenced “clinical teaching point” based on the patient. SOAP note should include: CC, HPI, PMH, SH, Allergies, Medication list and prior meds if available (including where filled, prescriber, adherence assessment if available), lab values, and hospital or clinical course As available include: FH, ROS, Physical exam. Assessment/plan should include assessment of all medications and health maintenance/preventive health issues.

| Type of Assessor (check one): | Expert ☐ Peer ☐ Student ☐ Date ________________ |
| Name of Presenter _________________________ | Evaluator __________________________________ |
| Presentation Title _________________________ | Formal Case # ___________________ |

**Evaluation Key:** NI = Needs Improvement  SP = Satisfactory Progress  ACH = Achieved  N/A=Not applicable

### Content—Presentation of CASE

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence/Comments</th>
<th>Evaluation</th>
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</thead>
<tbody>
<tr>
<td>1. Collects and presents all pertinent patient information</td>
<td></td>
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<tr>
<td>2. Evaluates current medications thoroughly for drug related problems, including adherence</td>
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<tr>
<td>3. Assesses patient problems appropriately including severity, etiology, risk factors, complications</td>
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<tr>
<td>4. Provides specific and appropriate recommendations for changes in therapeutic plan</td>
<td></td>
<td></td>
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<tr>
<td>5. Provides clear rationale for recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Provides specific and appropriate monitoring parameters for changes in therapeutic plan</td>
<td></td>
<td></td>
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<tr>
<td>7. Provides appropriate health maintenance/preventive strategies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. References literature/guidelines as appropriate</td>
<td></td>
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</tbody>
</table>

### Content—Presentation of TEACHING POINT

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence/Comments</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Presents the clinical content in sufficient detail to demonstrate thorough understanding</td>
<td></td>
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</tr>
<tr>
<td>2. Presents relevant patient-specific and disease-specific background information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Effectively uses appropriate primary literature and guidelines</td>
<td></td>
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<tr>
<td>4. Demonstrates understanding of the therapeutic approach to management of the patient’s problems</td>
<td></td>
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<tr>
<td>5. Effectively integrates patient case with topic discussion</td>
<td></td>
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<tr>
<td>6. Provides clear recommendations based on synthesis of all primary literature and current applicable guidelines</td>
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</table>
## COMMUNICATION

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence/Comments</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Demonstrates thorough understanding of the topic</td>
<td></td>
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<tr>
<td>2. Presents at an appropriate level for the audience, clearly explaining difficult concepts</td>
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<tr>
<td>3. Demonstrates ability to adapt if needed</td>
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<tr>
<td>4. Makes smooth transitions between concepts</td>
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<tr>
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<tr>
<td>6. Clearly explains difficult concepts</td>
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<td></td>
</tr>
<tr>
<td>7. Allows adequate time for audience to follow-along when discussing tables, graphs, illustrations</td>
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<td></td>
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<tr>
<td>8. Maintains audience interest</td>
<td></td>
<td></td>
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<tr>
<td>9. Maintains appropriate voice rate, quality, tone, and volume with articulation and engaging inflection</td>
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<td>10. Maintains appropriate eye contact with audience</td>
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<td></td>
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<tr>
<td>15. Responds to questions thoroughly and tactfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Avoids distracting mannerisms during presentation</td>
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</table>

## Visual Aids (SOAP note + handout +/- ppt, other)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence/Comments</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SOAP note format is appropriate, well designed with logical flow.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Teaching point handout is effectively developed to support learning and be used as a future reference</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Teaching point handout is appropriately referenced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Assists in understanding of the material and is not distracting from the presentation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Handout has no or very limited typos</td>
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</tbody>
</table>

### Overall Evaluation

<table>
<thead>
<tr>
<th>Overall Presentation</th>
<th>Evidence/Comments</th>
<th>Evaluation</th>
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<tbody>
<tr>
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</tbody>
</table>

### Areas of strength (required):

### Areas to focus on for enhancement/improvement (required):

### Overall Insights or Comments:
Goal R4.1: Provide effective education and/or training.
Objective R4.1.2: (Applying) Use effective presentation and teaching skills to deliver education programs to targeted audiences including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.
Objective R4.1.3: (Applying) Develop effective written communication skills to provide educational information to multiple levels of learners including patients, caregivers, and members of the community; health profession students; pharmacists; and other health care professionals.

Instructions: Choose a topic that is of interest to you and the other residents. At least one week before your topic discussion, send out any pre-work you expect the audience to complete in order for you to provide a more robust topic discussion. During your discussion, use active learning strategies to assist in learning advanced details. Provide a handout including objectives and references. Plan for the topic discussion to last 30-40 minutes.

Type of Assessment (check one): Expert □ Peer □ Student □ Self □ Date ________________________
Name of Presenter ___________________________ Evaluator ___________________________
Topic __________________________________________ #1 or 2?

Evaluation Key: NI = Needs Improvement SP = Satisfactory Progress ACH = Achieved NA = Not applicable

<table>
<thead>
<tr>
<th>EVALUATION CRITERIA</th>
<th>Comments / Evidence</th>
<th>Evaluation</th>
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</thead>
<tbody>
<tr>
<td><strong>Prework</strong></td>
<td>Presenter addressed/includes the following components:</td>
<td></td>
</tr>
<tr>
<td>6. Sent the prework out one week in advance.</td>
<td></td>
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<tr>
<td>7. Provided learning objectives for the prework.</td>
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<tr>
<td>8. The amount of prework was acceptable.</td>
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<tr>
<td>9. The content of the prework was appropriate.</td>
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<tr>
<td>10. Appropriate resources or guidelines were referred to or provided (as needed) to complete the prework objectives.</td>
<td></td>
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</tr>
<tr>
<td><strong>Content of Topic Discussion</strong></td>
<td>Presenter evaluates the study based on the following components:</td>
<td></td>
</tr>
<tr>
<td>8. Provided objectives for the topic discussion.</td>
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<tr>
<td>9. Provided appropriate amount of background related to the pathophysiology, therapeutics, administration, etc.</td>
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<tr>
<td>10. Discussed pharmacotherapy and treatment algorithms as appropriate to the topic</td>
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<tr>
<td>11. Considered patient-specific factors such as cost and adherence.</td>
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<tr>
<td>12. As appropriate and time permitting, discussed special populations or exceptions for therapy.</td>
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<tr>
<td>13. Content was accurate and complete for given timeframe.</td>
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<td>14. Content was prioritized appropriately.</td>
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<tr>
<td>EVALUATION CRITERIA</td>
<td>Comments / Evidence</td>
<td>Evaluation</td>
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<tr>
<td>Active Learning</td>
<td>Presenter</td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>Used active learning that is relevant in the context of topic.</td>
<td></td>
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<tr>
<td>2.</td>
<td>Used unique or appropriate active learning strategies effectively.</td>
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<tr>
<td>3.</td>
<td>Ensured active learning assisted in the audience learning the objective(s).</td>
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<tr>
<td>Handout</td>
<td>5.</td>
<td></td>
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<tr>
<td>6.</td>
<td>Handout assisted in understanding of the material and was not distracting from the presentation.</td>
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<tr>
<td>7.</td>
<td>Was appropriately referenced.</td>
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<td>8.</td>
<td>Had no or very limited typos</td>
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<td></td>
<td>Effectively developed to support learning and be used as a future reference</td>
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<tr>
<td>Communication skills</td>
<td>17.</td>
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<td>18.</td>
<td>Presented at an appropriate level for the audience, clearly explaining difficult concepts</td>
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<td>19.</td>
<td>Demonstrated ability to adapt if needed</td>
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<td>20.</td>
<td>Made smooth transitions between concepts</td>
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<td>21.</td>
<td>Clearly summarized important information (organized and logical)</td>
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<td>Clearly explained difficult concepts</td>
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<tr>
<td>23.</td>
<td>Allowed adequate time for audience to follow-along when discussing tables, graphs, illustrations</td>
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<tr>
<td>24.</td>
<td>Maintained audience interest</td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>Maintained appropriate voice rate, quality, tone, and volume with articulation and engaging inflection</td>
<td></td>
</tr>
<tr>
<td>26.</td>
<td>Maintained appropriate eye contact with audience</td>
<td></td>
</tr>
<tr>
<td>27.</td>
<td>Used effective body language and expression</td>
<td></td>
</tr>
<tr>
<td>28.</td>
<td>Used correct pronunciation of terminology</td>
<td></td>
</tr>
<tr>
<td>29.</td>
<td>Displayed professionalism in communication style</td>
<td></td>
</tr>
<tr>
<td>30.</td>
<td>Responded to questions thoroughly and tactfully</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoided distracting mannerisms during presentation</td>
<td></td>
</tr>
<tr>
<td>Overall</td>
<td>Overall performance evaluation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Demonstrated thorough understanding of the topic with confidence and credibility.</td>
<td></td>
</tr>
</tbody>
</table>

**Overall insights or Comments:**

**Areas of strength (required):**

**Areas to focus on for enhancement/improvement (required):**
# STATS PRESENTATION EVALUATION

Check one: Pharmacist  □  Resident  □  Student  □

## LECTURE CONTENT EVALUATION

For each lecture objective (LO), score as:

1=Strongly Disagree  2=Disagree  3=Agree  4=Strongly Agree

<table>
<thead>
<tr>
<th>LO discussed in appropriate depth</th>
<th>LO was understandable</th>
<th>Examples related to LO were appropriate</th>
<th>Comments about LO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describe the elements of study design and evaluate the strengths and weaknesses of various study designs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluate the validity of a clinical trial in an effort to determine quality of study design and applicability to other populations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Select the appropriate statistical test and determine whether results are statistically/clinically significant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpret the results of a clinical trial utilizing a confidence interval and performing data-based calculations</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Overall, I learned from this presentation. Circle one:  Yes  Only a little  No

Overall feedback about CONTENT of presentation:

---

## COMMUNICATION EVALUATION

Key:  NI = Needs Improvement  S = Satisfactory  E = Excellent

### COMMUNICATION - SPEAKER 1 name:

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence/Comments</th>
<th>Evaluation (NI, S, E)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstrates understanding of the presented information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presents information in an organized and logical sequence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clearly explains difficult concepts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allows adequate time for audience participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains audience interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains appropriate voice rate, quality, tone, and volume</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains appropriate eye contact with audience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Uses correct pronunciation of terminology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Displays confidence and credibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Responds to questions thoroughly and tactfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids distracting mannerisms during presentation</td>
<td></td>
<td></td>
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</table>
## COMMUNICATION EVALUATION

**Key:** NI = Needs Improvement  S = Satisfactory  E = Excellent

### COMMUNICATION - SPEAKER 2 name: ________________

<table>
<thead>
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<th>Criteria</th>
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<tbody>
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<td>• Demonstrates understanding of the presented information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presents information in an organized and logical sequence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clearly explains difficult concepts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allows adequate time for audience participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains audience interest</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains appropriate eye contact with audience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Displays confidence and credibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Responds to questions thoroughly and tactfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids distracting mannerisms during presentation</td>
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</table>

### COMMUNICATION - SPEAKER 3 name: ________________

<table>
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<td>• Demonstrates understanding of the presented information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Presents information in an organized and logical sequence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clearly explains difficult concepts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Allows adequate time for audience participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains audience interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains appropriate voice rate, quality, tone, and volume</td>
<td></td>
<td></td>
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<tr>
<td>• Maintains appropriate eye contact with audience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Displays confidence and credibility</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids distracting mannerisms during presentation</td>
<td></td>
<td></td>
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</table>

### COMMUNICATION - SPEAKER 4 name: ________________

<table>
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<td></td>
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<tr>
<td>• Presents information in an organized and logical sequence</td>
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</tr>
<tr>
<td>• Clearly explains difficult concepts</td>
<td></td>
<td></td>
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<tr>
<td>• Allows adequate time for audience participation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains audience interest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maintains appropriate voice rate, quality, tone, and volume</td>
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<td></td>
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<tr>
<td>• Maintains appropriate eye contact with audience</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Displays confidence and credibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Responds to questions thoroughly and tactfully</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoids distracting mannerisms during presentation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Drug Information Request & Response Form

<table>
<thead>
<tr>
<th>Date of DI request:</th>
<th>Answer Due By:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request taken by:</td>
<td>___ Rush (0-2 hours) ___ No Rush (&lt;1 week)</td>
</tr>
<tr>
<td></td>
<td>___ ASAP (&lt;24 hours) ___ Specific Date/time</td>
</tr>
</tbody>
</table>

**Demographics and contact information of requestor:**

<table>
<thead>
<tr>
<th>Name/title:</th>
<th>If Health Professional:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Pharmacist (internal)</td>
</tr>
<tr>
<td></td>
<td>□ Pharmacist (external)</td>
</tr>
<tr>
<td></td>
<td>□ Physician</td>
</tr>
<tr>
<td></td>
<td>□ Nurse</td>
</tr>
<tr>
<td></td>
<td>□ Technician</td>
</tr>
<tr>
<td></td>
<td>□ Industry representative</td>
</tr>
<tr>
<td></td>
<td>□ Other _____________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization:</td>
</tr>
<tr>
<td>Phone#:</td>
</tr>
<tr>
<td>e-mail:</td>
</tr>
<tr>
<td>fax:</td>
</tr>
</tbody>
</table>

**If patient:**

<table>
<thead>
<tr>
<th>Their pharmacy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Their physician?</td>
</tr>
</tbody>
</table>

| Age: |
| Sex: |

**Allergies:**

<table>
<thead>
<tr>
<th>Health conditions:</th>
</tr>
</thead>
</table>

**Classify Question:**

- □ Adverse Drug Reaction
- □ Drug Interaction
- □ Pregnancy/Lactation
- □ Dose or regimen
- □ Pharmacotherapy
- □ Compounding
- □ Drug Administration
- □ Stability/compatibility
- □ Pharmacokinetics
- □ Indication
- □ Toxicology
- □ Articles request
- □ Tablet or product ID
- □ Product Availability or cost
- □ Pharmacology
- □ Other
- □ Natural Products/herbals/CAM
- □ Teratogenicity

**Initial Question from the Requestor:**

**Background information needed to clarify request or answer question:**

**Actual Question (e.g. if upon clarification the question changes or re-worded clinically):**
Search strategy: _____3◦ _____2◦ _____1◦ _____Personal Communication (list below)

**Sources:** list ALL references consulted to prepare response along with notes or analysis of the source. Put in order that you searched it.

<table>
<thead>
<tr>
<th>Source</th>
<th>Analysis of Source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Personal Communication Attempted (drug companies, experts, etc.):**

| Name: ___________________ | Name: ___________________ |
| Company: ________________ | Company: ________________ |
| Phone: _________________ | Phone: _________________ |

**Response:**

Write an accurate response and draw appropriate conclusions from the literature evaluation, based on the patient if applicable. May include appendices of the actual letter to the provider or patient if completed.

**Response Information:**

<table>
<thead>
<tr>
<th>Response:</th>
<th>Materials Sent:</th>
<th>Time requirement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Answer Only</td>
<td># Pages copied ____</td>
<td><strong>Answer Completed by whom:</strong></td>
</tr>
<tr>
<td>□ Material Only</td>
<td># Pages faxed ____</td>
<td>___________________</td>
</tr>
<tr>
<td>□ Both</td>
<td>Cost of Postage ____</td>
<td><strong>Date______________ Time______________</strong></td>
</tr>
</tbody>
</table>
Drug Information Response Evaluation

This evaluation should be completed by the preceptor at that site or the RPD.

Goal R5.2: Provide concise, applicable, comprehensive, evidence-based, and timely responses to requests for drug information from health care providers and patients.

OBJ R5.2.1: (Analysis) Discriminate between the requesters’ statement of need and the actual drug information need by asking for appropriate additional information.

OBJ R5.2.2: (Synthesis) For drug information requests that can be met by drawing upon one’s memory, provide appropriate, evidence-based responses.

OBJ R5.2.3: (Synthesis) When the drug information request requires further evaluation of the literature, formulate a systematic, efficient, and thorough procedure for retrieving drug information.

OBJ R5.2.4: (Analysis) When the drug information request requires further evaluation of the literature, assess the usefulness of biomedical literature gathered.

OBJ R5.2.5: (Synthesis) When a drug information request requires further evaluation of the literature, provide evidence-based responses to drug information requests based on that evaluation.

<table>
<thead>
<tr>
<th>Present needs to be rewritten</th>
<th>Item/section needs many revisions</th>
<th>Item/section needs a few revisions</th>
<th>Item/section needs very minor or minimal revision</th>
<th>Item/section needs no revision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>0% - 60%</td>
<td>70%</td>
<td>80%</td>
<td>90%</td>
<td>100%</td>
</tr>
</tbody>
</table>

THINKING & DECISION-MAKING

Request
Restates the consult question, in student’s own words, accurately incorporating any clarification information received to demonstrate understanding

Background
Provides a pertinent, brief overview/background (1-2 paragraphs) that provides an appropriate context for answering the question; targets the appropriate audience; establishes credibility

Primary Literature
Describes briefly and accurately the literature/evidence that has been analyzed and synthesized in the consult. This may include a discussion of study designs, outcomes, study durations, and sample sizes.
Discusses how studies were included or excluded in the consult.

Evidence-Based Conclusion/Recommendation
Supports conclusions/recommendations with specific, pertinent evidence and data from the literature analyzed for the consult.
Recommendations are fully supported with solid rationale and accurate critique of the literature.
Accurately represents and synthesizes the literature analyzed for the consult. Clinical interpretation and extrapolation of the literature is correct. If needed, provides specific and convincing recommendations for additional study or cites parameters that might influence recommendations.

Search Strategy & References/Citations
Performs an appropriate, effective and efficient literature search (based on the description of search strategy submitted—sources used, databases searched, search terms used, etc.)
Retrieves all pertinent literature to answer the question.
Cites references according to guidelines for biomedical journals.

COMMENTS ON THINKING & DECISION-MAKING
<table>
<thead>
<tr>
<th><strong>COMMUNICATION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provides a clear, concise and accurate conclusion/recommendation</td>
</tr>
<tr>
<td>Provides credible and persuasive conclusion/recommendation</td>
</tr>
<tr>
<td>Uses appropriate terminology</td>
</tr>
<tr>
<td>Begins each paragraph with a clear topic sentence</td>
</tr>
<tr>
<td>Uses effective transitions between paragraphs/ideas</td>
</tr>
<tr>
<td>Writes in a professional style throughout</td>
</tr>
<tr>
<td>Uses correct grammar and spelling</td>
</tr>
</tbody>
</table>

**COMMENTS ON COMMUNICATION**

---

**OVERALL PERFORMANCE**

---
St. Louis Metropolitan Area Resident Seminar and Fellow Seminar Evaluation

<table>
<thead>
<tr>
<th>Presenter’s Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Title

Assessor: (check one)  ☐ Pharmacist  ☐ Resident  ☐ Student

I. CONTENT

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly summarizes importance/relevance of topic in introduction</td>
<td></td>
</tr>
<tr>
<td>Presents relevant background information</td>
<td></td>
</tr>
<tr>
<td>Selects appropriate primary literature</td>
<td></td>
</tr>
<tr>
<td>Adequately summarizes and presents pertinent methods (including statistics)</td>
<td></td>
</tr>
<tr>
<td>Adequately summarizes and presents pertinent results</td>
<td></td>
</tr>
<tr>
<td>Critically evaluates quality of primary literature</td>
<td></td>
</tr>
<tr>
<td>Synthesizes own conclusions based on critical appraisal of the literature</td>
<td></td>
</tr>
<tr>
<td>Applies and connects separate content areas to build to a conclusion</td>
<td></td>
</tr>
<tr>
<td>Provides clear recommendations based on synthesis of all primary literature</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
### II. COMMUNICATION

<table>
<thead>
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<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrates professional behavior</td>
<td></td>
</tr>
<tr>
<td>Uses appropriate terminology for level of audience</td>
<td></td>
</tr>
<tr>
<td>Displays confidence through command of subject matter</td>
<td></td>
</tr>
<tr>
<td>Presents information in an organized and logical sequence</td>
<td></td>
</tr>
<tr>
<td>Uses smooth transitions between and within content areas</td>
<td></td>
</tr>
<tr>
<td>Purposefully uses audiovisuals to enhance presentation (font is clear and visible, microphone is appropriate, etc)</td>
<td></td>
</tr>
<tr>
<td>Uses appropriate balance of text and figures in slides</td>
<td></td>
</tr>
<tr>
<td>Effectively develops handout to be used as a future reference</td>
<td></td>
</tr>
<tr>
<td>Maintains good voice quality, rate and tone</td>
<td></td>
</tr>
<tr>
<td>Effectively uses body language to augment and not distract from presentation</td>
<td></td>
</tr>
<tr>
<td>Uses time efficiently and effectively</td>
<td></td>
</tr>
<tr>
<td>Answers questions accurately and respectfully</td>
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</table>

**Comments:**

### III. OVERALL

<table>
<thead>
<tr>
<th>Overall Presentation</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>NI = Needs Improvement</td>
<td>SP = Satisfactory Presentation</td>
</tr>
<tr>
<td>Overall Presentation</td>
<td></td>
</tr>
</tbody>
</table>
Appendix: Quantifi®

STLCOP User Instructions
Quantifi®, Pharmacy OneSource Product by Wolters Kluwer, is a clinical intervention documentation system. Students on community care, ambulatory care, acute care, and patient care selective APPEs as well as community IPPE rotations are required to document every intervention they make during the rotation using Quantifi. Some faculty and residents also use the system. Users should document on a daily basis to assure the correct date of the intervention is recorded. Even if interventions are documented in an internal site-specific system, students are also required to document them in Quantifi on the required rotations.

CONTENTS:

I. USER SIGN IN
II. DOCUMENT AN INTERVENTION
III. DOCUMENT MULTIPLE QUICK INTERVENTIONS
IV. INTERVENTIONS
V. QUANTIFI® FAQS & HELP

I. USER SIGN IN

A. Open your Internet browser (Internet Explorer is preferred)
B. Access the Quantifi website at: http://www.pharmacyonesource.com/products/quantifi/
C. For optimal viewing and functionality of the website, click the “compatibility” icon ONE time if new IE version – it looks like a BLUE piece of paper torn in half (circled in red below):

![Compatibility Icon](https://example.com)

That ensures compatibility with your current web browser version and you do not need to repeat this step until you install a new web browser version.

D. Click “Product Login” at upper right hand side of page
E. Select “Quantifi” from the list of Products
F. Login using the following information:
   1. Site ID = 3110
      • Check box “Remember Site ID” to store ID number (this is highly recommended)
      • This site ID is for all users from St. Louis College of Pharmacy
   2. User ID = Assigned
   3. Password = Assigned
      • Forgot your User ID or Password? Please contact Michelle Mele (314-446-8493 or Michelle.Mele@stlcop.edu) in the Office of Experiential Education.
      • Users should change their password after first successful login—
         o Password requirements: minimum length = 8 characters (a minimum of 2 alphabetical letters plus a minimum of 2 numerals). Password is required to be changed every 365 days.
   4. Click “Sign In”
G. You should now see the following “home” screen:

II. DOCUMENT AN INTERVENTION

A. Begin to document an intervention by clicking “User View” under the Quantifi section on the left-hand sidebar (circled in above screenshot in RED) to expand the section.

B. Click “Documentation” to expand the section.

C. Click “Intervention” to open the standardized clinical documentation form (used for all clinical interventions). The form will look like this:

D. “Event” Section: Document specific information for all interventions on a specific patient encounter.

   1. Event Date (REQUIRED): Document the exact date OF THE INTERVENTION, not the date of the documentation.
      • This field will automatically populate with today’s date. CHANGE the date if the actual intervention occurred on a previous date.
      • The use of the calendar function is optional.
2. **Service (REQUIRED):** Select your clinical practice site.
   - CLICK on either the field or the drop-down arrow to reveal the list of available practice sites.
   - Then, either enter the first letter of your practice site to jump to the beginning of the alphabetized sites starting with that letter (e.g. entering “s” will bring you to the beginning of the “s” section); however, this field does not have an autocomplete functionality.

3. **Primary Drug (OPTIONAL):** Document the most important drug related to the primary intervention (if appropriate).
   - Drug names in this list are usually GENERIC drug names, although some combination drugs are listed as their trade name, so look for these also. Some chemotherapy regimens are listed by their acronym.
   - There are two possible methods to find a generic drug name, you may either:
     - CLICK on the Primary Drug field and begin typing the generic name of the drug. This field uses autocomplete functionality (e.g. typing “gab” will autoselect the drug name “gabapentin”). **OR**
     - CLICK on the “magnifying glass” icon to the right of the drug field to bring up an alphabet. CLICK on the beginning letter of the drug name for which you are searching. Then scroll down and CLICK on the specific drug desired to be selected.
   - The icon to the right of the magnifying glass icon, a tiny letter “i” within a circle, provides a quick link to a drug information program called “DIONe” (a separate Wolters Kluwer product). You may use this to look up information about a specific drug.

4. **Other Drug (OPTIONAL):** Use this field to document an additional drug that is relevant to either the primary or a secondary intervention. Follow the same steps as in #3 above to select a second drug name, if appropriate.

5. **1° Intervention (REQUIRED):** Document the most important intervention for a given patient encounter.
   - Refer to the Interventions section for definitions of each intervention. It is very important to select the most appropriate intervention type.
   - Although there are two possible methods for selecting a 1° Intervention, the preferred method is to CLICK on the lower box (the one with a drop-down arrow) to bring up a drop down list of all available interventions. Then select the most relevant intervention for a given patient encounter. Your selection will then appear in both fields (upper and lower) for the 1° Intervention.

6. **2° Intervention (REQUIRED):** Use this field to document unlimited additional interventions for a given patient encounter.
   - If there is no secondary intervention, select “NO SECONDARY Intervention”.
   - Use preferred method for selecting an intervention described in #5 above to select a 2° intervention.
   - CLICK the button labeled “Add >” to add the intervention to the box to the right of the 2° Intervention field. This is a necessary step to “capture” any 2° Interventions.
   - To remove a 2° Intervention from the “captured” list, just CLICK the intervention to highlight it and then CLICK the “Remove” button.
7. **Notes (OPTIONAL):** If you would like to add a brief description of any additional information that would clarify the intervention or the context, then you may use this field.
   - **IMPORTANT:** **DO NOT ENTER ANY INFORMATION THAT COULD POSSIBLY IDENTIFY THE PATIENT INCLUDING PATIENT INITIALS.** HIPAA REGULATIONS PROHIBIT THE DOCUMENTATION OF ANY IDENTIFYING INFORMATION IN THIS SYSTEM!

8. **Time Taken (REQUIRED):** Document the TOTAL time taken for all work related to all interventions for a given patient encounter.
   - Interventions have an “estimated” time duration that will automatically populate in this field.
   - **If your actual time taken is different from this value, then over-write the time** by highlighting the number in the field and typing the new/actual total time.

E. **“Outcome” Section:** Document the acceptance of the intervention(s) by the health care professional and the expected/intended clinical or economic outcome for the patient or health care system.

1. **Was the primary intervention accepted? (REQUIRED).** Choose the answer that best corresponds with the acceptance by the health care professional:
   - **Yes** (default selection) – the intervention was accepted by the professional
   - **No** – the intervention was not accepted by the professional.
     - If this answer is selected, then an additional question will be asked: Do you want to apply the cost savings for the related secondary interventions? You will then need to select either “Yes” (default) or “No” as appropriate.
   - **Other** – choose this answer if 1) the outcome is either “pending” or “unknown”; 2) another health care professional is not involved in the intervention; 3) the intervention was covered by a Medication Therapy Services protocol; or 4) any other reason.
     - If this answer is selected, then an additional question will be asked: Do you want to apply the cost savings for all interventions? You will then need to select either “Yes” (default) or “No” as appropriate.

2. **Primary Physician (REQUIRED):** Please document the category of health care professional mostly involved in intervention(s).
   - Although there are two possible methods for selecting a Primary Physician, the preferred method is to CLICK on the lower box (one with drop-down arrow) to bring up a drop down list of all available health care professionals. Then select the most relevant professional for the overall patient encounter. Your selection will then appear in both fields (upper and lower) for the 1° Intervention.

3. **Outcome (REQUIRED):** Document the anticipated clinical outcome for the intervention(s).
   - Use preferred method for selecting an outcome described in #2 above (for Primary Physician) to select an outcome.
   - CLICK the button labeled “Add >” to add the outcome to the box to the right of the Outcome field. This is a necessary step to “capture” any outcomes.
   - To remove an outcome from the “captured” list, just CLICK the outcome to highlight it and then CLICK the “Remove” button.

4. **Notes (OPTIONAL):** Document any additional information you wish to add about the outcome in this field. NO PHI ALLOWED.

F. **Click the “Submit” button (REQUIRED)**

G. **Logout:** The system will automatically log you out after a period of inactivity, but it is always a good idea to logout when you have completed documenting your interventions.
III. DOCUMENT MULTIPLE QUICK INTERVENTIONS

A. Use this functionality ONLY IF you want to document MULTIPLE interventions of the exact same intervention type (e.g. multiple vaccinations during an immunization clinic). Begin by clicking "User View" under the Quantifi section on the left-hand sidebar (see page 1 screenshot in RED) to expand the section.

B. Click "Documentation" to expand the section.

C. Click "Intervention Quick" to open the QUICK clinical documentation form (used for SELECTED clinical interventions). The form will look like this below:

![Quick Intervention Documentation Form]

D. **"Event" Section:** Document specific information for all interventions on a specific patient encounter.

1. **Event Date (REQUIRED):** Document the exact date OF THE INTERVENTION, not the date of the documentation.
   - This field will automatically populate with today’s date. CHANGE the date if the actual intervention occurred on a previous date.
   - The use of the calendar function is optional.

2. **Intervention (REQUIRED):** Document the intervention for a given set of similar patient encounters.
   - Only the following interventions are available for the Quick form.
     - *Not specified*
     - *Other - Leave Note*
     - Administered a vaccine
     - Coordinated care (administrative intervention)
     - Educated a health professional
     - Educated a patient or caregiver
     - Facilitated obtaining a medication at discharge
     - Obtained a medication (patient assistance program)
     - Obtained prior authorization approval
     - Performed a screening test for early detection
     - Performed point-of-care test using a device
   - Although there are two possible methods for selecting a intervention, the **preferred** method is to CLICK on the lower box (one with drop-down arrow) to bring up a drop down list of all available interventions. Then select the most relevant intervention for a given patient encounter. Your selection will then appear in both fields (upper and lower) for the Intervention.
3. **Number to Submit (REQUIRED):** Document the **TOTAL** number of patient encounters with the identical intervention type.

4. **Time Taken (REQUIRED):** Document the **TOTAL** time taken for all work related to ALL (cumulative) interventions for a given patient encounter.
   - Interventions have an “estimated” time that will automatically populate in this field that is pre-calculated.
   - **If your actual time taken is different from this value, then over-write** the time by highlighting the number in the field and typing the new/actual total time.

5. **User Name:** Document the person responsible for the intervention(s). This field will automatically populate with the name of the user that signs in to the system. This field is not modifiable.

6. **Check box for “Add additional information to these interventions” (REQUIRED):** Document key details of the set of interventions. This box must be “checked” by the submitter. If this box remains “unchecked”, then the user will receive an error message that reads “Service is a required field” when the submit button is clicked.

7. **Service (REQUIRED):** Please select your clinical practice site.
   - CLICK on either the field or the drop-down arrow to reveal the list of available practice sites.
   - Then, either enter the first letter of your practice site to jump to the beginning of the alphabetized sites starting with that letter (e.g. entering “s” will bring you to the beginning of the “s” section); however, this field does NOT have an autocomplete functionality.

8. **Primary Drug (OPTIONAL):** Document the **most important drug** related to the primary intervention (if appropriate).
   - Drug names in this list are usually **GENERIC** drug names, although some combination drugs are listed as their trade name, so look for these also. Some chemotherapy regimens are listed by their acronym.
   - There are two possible methods to find a generic drug name, you may either:
     - CLICK on the Primary Drug field and begin typing the generic name of the drug. This field uses autocomplete functionality (e.g. typing “gab” will autoselect the drug name “gabapentin”.) **OR**
     - CLICK on the “magnifying glass” icon to the right of the drug field to bring up an alphabet. CLICK on the beginning letter of the drug name for which you are searching. Then scroll down and CLICK on the specific drug desired to be selected.
   - The icon to the right of the magnifying glass icon, a tiny letter “i” within a circle, provides a quick link to a drug information program called “DIOne” (a separate Wolters Kluwer product). You may use this to look up information about a specific drug.

9. **Notes (REQUIRED):** You must document additional information about the set patient encounters. Include information about the circumstances and/or setting for which the multiple interventions were made in individuals during the same interval (e.g. flu shot clinic, etc.). NO PHI ALLOWED.

10. **Click the “Submit” button (REQUIRED)**

11. **Logout:** The system will automatically log you out after a period of inactivity, but it is always a good idea to logout when you have completed documenting your interventions.
IV. INTERVENTIONS

A. Interventions List
The following intervention types are available. Users should refer to the definitions below to assist in choosing an intervention type. Although “Other-add note” is available if the intervention does not fit, users should first review the options and limit the use of this choice.

<table>
<thead>
<tr>
<th>Administered a vaccine‡</th>
<th>Monitored a medication (drug-specific parameter)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answered a DI question</td>
<td>Obtained a medication (patient assistance program) ‡</td>
</tr>
<tr>
<td>Clarified a medication order</td>
<td>Obtained prior authorization approval‡</td>
</tr>
<tr>
<td>Coordinated care (administrative intervention)‡</td>
<td>Participated in resuscitation attempt (code blue)</td>
</tr>
<tr>
<td>Discontinued an existing medication</td>
<td>Performed a CMR with a MTM platform</td>
</tr>
<tr>
<td>Educated a health professional‡</td>
<td>Performed a drug regimen review</td>
</tr>
<tr>
<td>Educated a patient or caregiver (general)‡</td>
<td>Performed a procedure</td>
</tr>
<tr>
<td>Educated a patient ON A DEVICE</td>
<td>Performed a screening test for early detection</td>
</tr>
<tr>
<td>Facilitated obtaining a medication at discharge‡</td>
<td>Performed a targeted intervention w/ a MTM platform</td>
</tr>
<tr>
<td>Initiated a new prescription medication</td>
<td>Performed medication reconciliation</td>
</tr>
<tr>
<td>Initiated a new OTC medication</td>
<td>Performed physical exam (includes vital signs)</td>
</tr>
<tr>
<td>Initiated a self-care regimen</td>
<td>Performed point-of-care test using a device‡</td>
</tr>
<tr>
<td>Made a referral</td>
<td>Reported an adverse drug event</td>
</tr>
<tr>
<td>Modified an existing medication</td>
<td>Resolved a medication error</td>
</tr>
<tr>
<td>Monitored a condition (disease-specific parameter)</td>
<td></td>
</tr>
</tbody>
</table>

“Other-add note” is available if the intervention does not fit any of the above criteria. Generally, the use of this choice should be limited.

‡ Available as a Quick Intervention to document multiple interventions within one day.

B. Intervention Definitions

*Not specified—Use this option if your intervention is not listed in the below menu of options. If you choose this option, then please contact Dr. Terry Seaton via email (Terry.Seaton@stlcop.edu) to discuss with him the possibility of adding another intervention category. This is a default category and not modifiable within Quantifi.

*Other-Leave Note—Use this option if your intervention is not listed in the below menu of options AND you will be entering a note or message that clarifies your intervention in greater detail. This is a default category and not modifiable within Quantifi.

Administered a vaccine—Use this option to document your personal administration of a vaccine. Do NOT use this option to administer any other medication that is NOT allowed by rule in the relevant state or federal law. Document total time taken, from any preparatory steps to documentation in the health record.

Answered a DI question—Use this option to document a response to ANY drug information question. Use this for DI questions from either another healthcare professional OR a patient/caregiver. Document total time taken, from literature search to analysis to preparation of any formal written response.

Clarified a medication order—Use this option to document an intervention on a problem drug order (inpatient) or prescription order (outpatient). Document total time taken, from contacting the prescriber (or designee) to communicating with pharmacy personnel.
**Coordinated care (administrative intervention)**—Use this option to document any intervention that involves care coordination (defined as the deliberate organization of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services). These interventions are usually administrative (commonly performed by a case manager) in nature and do not usually involve clinical activities. Nonetheless, they are necessary interventions that are intended to improve the quality and/or safety of patient care and fit within the scope of practice for a clinical pharmacist. Examples include, but are not limited to:
- answering phone calls from families, addressing their needs;
- coordinating home care services and medical equipment and supplies;
- sharing information with other health professionals;
- helping with transition issues; or
- linking families with other families for support.
Please document the total time taken to ensure that care is optimally coordinated (including all communication with patient/caregiver and other healthcare professionals).

**Discontinued an existing medication**—Use this option to document your intervention of stopping a specific medication in a given patient.

**Educated a health professional**—Use this option to document any informal or formal education of another healthcare professional or group of professionals. Document total time taken, from searching for information to developing any educational materials or communications.

**Educated a patient or caregiver (general)**—Use this option to document ANY informal or formal education of a patient and/or their caregiver or a group of patients beyond label instructions or common information. Document total time taken, from searching for information to developing any educational materials or communications.

**Educated a patient ON A DEVICE**—Use this option only when educating a patient on the proper use of a device (e.g. metered-dose inhaler [MDI], dry powder inhaler [DPI], glucometer or other point-of-care testing device). Choose a corresponding drug (e.g. albuterol or salmeterol, etc.), if applicable.

**Facilitated obtaining a medication at discharge**—Use this option to document your contribution to the discharge planning process for a patient in the acute care setting. Include all time spent facilitating the optimization of medication use during this important transition of care.

**Initiated a new prescription medication**—Use this option to document your initiation of any new prescription medication in a given patient.

**Initiated a new OTC medication**—Use this option to document your initiation of an over-the-counter medication in a given patient.

**Initiated a self-care regimen**—Use this option to document your initiation of a self-care recommendation for a given patient (e.g., exercise, diet, environmental fall prevention techniques, first aid, etc.)

**Made a referral**—Use this option when formally referring a patient to another health professional (e.g. physician, nurse, dietician, physical therapist, pharmacist, etc.) for any health care-related service.
Modified an existing medication—Use this option to document your modification of an existing medication. This includes changing the dose, route, frequency, dosage form, or anything else while keeping the original medication/chemical entity.

Monitored a condition (disease-specific parameter)—Use this option to document your obtaining a parameter for the purpose of monitoring a DISEASE or a CONDITION. Please distinguish this intervention from monitoring a medication (see below) by asking the question, “WHY am I monitoring this parameter?”

Monitored a medication (drug-specific parameter)—Use this option to document your obtaining a parameter for the purpose of monitoring a MEDICATION. Please distinguish this intervention from monitoring a disease or condition (see above) by asking the question, “WHY am I monitoring this parameter?”

NO SECONDARY Intervention—Use this ONLY for fulfilling the requirement to document a secondary intervention, when no secondary intervention exists. This is not an option as a primary intervention type.

Obtained a medication (patient assistance program)—Use this option to document the procurement of a medication for a patient through a formal patient assistance program. Please document the total time taken for all phases, from determining eligibility to completing the necessary paperwork to communications with the patient and/or healthcare professional.

Obtained prior authorization approval—Use this option to document your obtaining authorization to use a medication (likely through a preferred drug program of a managed care company or Medicaid). Please also use this option when you authorize the use of a medication (e.g. as a step in an antibiotic stewardship program in a hospital). Include the total time taken for all aspects of the process.

Participated in resuscitation attempt (code blue)—Use this option when you are involved on a rapid response team to resuscitate a patient who has cardio-respiratory arrest. Include total time taken, from the time of the call to the documentation (if necessary).

Performed a drug regimen review—Use this option to document a comprehensive review (i.e. assessing for appropriateness of medications, drug interactions, adverse drug reactions, and cost) of a patient’s regimen. Instances of a quick perusal of patient’s medication list, by itself, does not warrant documentation as an “intervention”. If this is done as part of a MTM platform, please choose a different intervention – Performed a (CMR or targeted intervention with an MTM platform.

Performed a procedure—Use this option to document your performing of any procedure in a specific patient (e.g. toenail care). Typically, this will have a corresponding CPT code (but document all procedures, regardless of billing). Procedures documented using this option must be allowed under the scope of practice for a pharmacist at your institution, as stipulated by law and/or credentialing body of the institution. Do NOT use this option for point-of-care testing (SEE BELOW, under Performed point-of-care test using a device).

Performed a screening test for early detection—Use this option to document your performing of any screening test in a patient. Make sure that you differentiate this option from others, such as Performed a procedure (above) or Performed a point of care test using a devise (below).
**Performed a CMR with a MTM platform**—Use this option to document a specific comprehensive medication review (CMR) on a formal MTM platform (e.g. Outcomes MTM, Mirixa, Direct Care Pro, or other system). Include total time taken for all phases and steps, including billing and providing the medication action plan (MAP) and personalized medication list (PML). For quick interventions such as TIPS or TMRs, please choose “Performed a targeted intervention with a MTM Platform.” For CMRs not involved with a platform, please choose “Performed a drug regimen review.”

**Performed a targeted intervention with a MTM platform**—Use this option to document a specific targeted or guided intervention using a MTM platform (e.g. Outcomes MTM, Mirixa, Direct Care Pro, or other system). Examples include, but are not limited to: targeted intervention program (TIP), adherence calls, new to therapy calls, late to fill calls, etc. Include total time taken for all phases and steps, including billing. For comprehensive medication reviews (CMRs), please choose “Performed CMR with a MTM platform.”

**Performed medication reconciliation**—Use this option when you conduct a comprehensive and complete medication reconciliation process in a patient that includes documenting and/or updating a complete medication list in the medical record. Include the total time taken, from collecting the medication history to verifying with community pharmacies (or other sources) to documenting in the medical record.

**Performed physical exam (includes vital signs)**—Use this option to document any physical exam in a specific patient. This will include obtaining vital signs. User may clarify the exam in the “Notes” section of Quantifi.

**Performed point-of-care test using a device**—Use this option to document the performance of any point-of-care test using a specific device. Include total time taken, from calibrating the device to documentation in the medical record.

**Reported an adverse drug event**—Use this option to document your formal reporting of an adverse drug event. This may be in a national pharmacovigilance system (e.g. FDA MedWatch) or in any local system within the institution or health system. Include total time taken.

**Resolved a medication error**—Use this option to document your resolution of a medication error. This should include an intervention in any category (i.e. “Unsafe Condition”, “Near Miss”, or “Medication Error”). Include total time taken for all steps in the process.

V. QUANTIFI® FAQS & HELP

1. Which internet browser is the best for Quantifi®?
   Internet Explorer is preferred and you should make sure your browser is compatible with the most updated version of the website (IE11). If you do not have this version, you can go to IT and have it installed.

2. What do I do if my practice site is not on the list?
   It may be that your rotation is not one that requires documentation of Quantifi® interventions. If you are on a community care, acute care, ambulatory care, or patient care selective, and you cannot find your site in the list, contact Michelle Mele (Michelle.Mele@stlcop.edu) and she can add it in there for you.
3. **What do I do if I can't find the drug on the list?**
   Drugs are listed usually by generic name only, so make sure you are looking up the generic drug name before selecting “Other”. If you still can’t find it, you can email Dr. Terry Seaton (Terry.Seaton@stlcop.edu) and request that he add the drug in the database. This would be preferred over entering in free text of the drug name.

4. **What do I do if I can’t find my intervention type?**
   Do not select “Other leave note” if there is another option in the system. Review the definitions of the interventions to help you select the right intervention type.

5. **When should I use the “QUICK” version of Quantifi®?**
   Use this ONLY if you are documenting MULTIPLE interventions of the exact same type (such as vaccinations during an immunization clinic).

6. **How many interventions do I need to enter?**
   You need to enter each and every intervention you make. That number will vary based on the patient care setting/rotation you are on. For community care, you are required to do 35 and 25 must be noted as AFP-related.

7. **Which date should I use when entering, the date of the intervention or the date of entry?**
   The date needs to match the date that the intervention occurred. If you elect to enter interventions batched at the end of each week, make sure to CHANGE the date and choose the date that the actual intervention occurred. If you accidentally enter the wrong date, you have 24 hours after an intervention is submitted to view and edit the documentation. To view or edit your documentation, click on user view, my reports, edit reports. This will show you all of the documentation you opened and can still edit.

8. **Should I still enter interventions into Quantifi if I am also entering them in my site-specific electronic health record system?**
   Yes, you should enter all interventions at the site and in Quantifi until we can identify a way to streamline this process.

9. **How/when should I use the “performed a drug regimen review” intervention option?**
   Use this option to document a comprehensive review (i.e. assessing for appropriateness of medications, drug interactions, adverse drug reactions, and cost) of a patient’s regimen. Instances of a quick perusal of a patient’s medication list or daily follow-up monitoring, by itself, do not warrant documentation as an “intervention”. This intervention is also different from “performed medication therapy management” as this refers to specific MTM platforms such as Mirixa or Outcomes.

10. **Should I include anything about the patient in the notes section?**
    No, do not put any PHI anywhere in the documentation of the intervention.

11. **How can edit or view my entries?**
    You have 24 hours after an intervention is submitted to view and edit the documentation. To view or edit your documentation, click on user view, my reports, edit reports. This will show you all of the documentation you opened and can still edit. After this 24 hour time period, you will need to contact Michelle Mele (314-446-8493 or Michelle.Mele@stlcop.edu) in the Office of Experiential Education in order to receive a report of your interventions.

12. **If I have other questions about Quantifi, who should I ask?**
    Michelle Mele can answer your question or guide you to another person for assistance.

Revised 4/4/2018
### Appendix: Resident projects by site and year

#### L&S Pharmacy Resident Projects

<table>
<thead>
<tr>
<th>Name and Year</th>
<th>Research project</th>
<th>Business Plan</th>
<th>New or Expanded Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassidy Domagalla</td>
<td>Impact of the Patient Health Questionnaire-2 (PHQ-2) used by Community Pharmacists on the Diagnosis and Treatment of Depression in Patients with Diabetes</td>
<td>Diabetes shoes</td>
<td>New collaborative practice agreement for diabetes shoes. Formalized health fair tracking sheet, forms, consults</td>
</tr>
<tr>
<td>Kristen Komaiko</td>
<td>Effect of an Adherence Program on A1c in Patients with Type II Diabetes Mellitus</td>
<td>Independent Community Pharmacy Transitions of Care (TOC) Program</td>
<td>Started MO Medicaid MTM program (MOHealthNet) and OutcomesMTM at L&amp;S. Implemented high risk medication program. Assisted with implementing the TOC program. Assisted in opening a new pharmacy in New Madrid.</td>
</tr>
<tr>
<td>Emily Hanson</td>
<td>Improving community pharmacy’s impact on performance measures “Star Ratings” and patient care: provider acceptance of pharmacist interventions to decrease high risk medications in the elderly</td>
<td>Weight loss program</td>
<td>Incentive program to increase the technician updating patient information in the computer. Designing and developing the transitions of care program and initial training of pharmacy staff.</td>
</tr>
<tr>
<td>Megan Snodgrass</td>
<td>Evaluation of a Community-Based Pharmacist-Run, Transitions of Care Program on 30-Day Readmission Rates</td>
<td>Evaluating patients taking metformin, PPIs, and opiates for medication-induced vitamin deficiencies</td>
<td>Determine ability to bill for patient care services. Collaboration with Bootheel Counseling Center to provide adherence counseling and cost control for medications for their patients, including children and adults.</td>
</tr>
<tr>
<td>Alex Majors</td>
<td>Analysis of Adherence Rates for Chronic Medications tied to Star Ratings Following Comprehensive Medication Review</td>
<td>Influenza Vaccination Service</td>
<td>Gaps in care. GSK COPD project.</td>
</tr>
<tr>
<td>Bianca Daisy</td>
<td>IPPE or APPE? Community Pharmacy Preceptor Perceptions of Where to Incorporate Specific Rotation Activities</td>
<td>TBD</td>
<td>Working with mental health partner to implement PHQ-9 assessment and additional mental health referrals.</td>
</tr>
</tbody>
</table>

#### Schnucks Pharmacy Resident Projects

<table>
<thead>
<tr>
<th>Name and Year</th>
<th>Research project</th>
<th>Business Plan</th>
<th>New or Expanded Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Essenpreis</td>
<td>Comparison of Medication Adherence in Patients with HIV Between Specialty and Grocery Community Pharmacies</td>
<td>Adding a new clinical pharmacist position</td>
<td>Call center pilot program</td>
</tr>
<tr>
<td>Mia Davelis</td>
<td>Cost-Effectiveness of Striibl Compared to Similar Antiretroviral Therapies</td>
<td>Developed and implemented a new way to deliver medications from the specialty location. New</td>
<td>Same as business plan. Also attempted to get new clinic site up and running at Casa de Salud (unfortunately not successful)</td>
</tr>
<tr>
<td>Name and Year</td>
<td>Research Project</td>
<td>Business Plan</td>
<td>New or Expanded Service</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Krista Hein 2014-2015</td>
<td>Community pharmacists’ comfort and knowledge of multiple sclerosis medications</td>
<td>Specialty pharmacy internal delivery service is being worked on.</td>
<td>Created a workflow operation for specialty pharmacy. Follow-up program for new multiple sclerosis patients.</td>
</tr>
<tr>
<td>Lauren Owens (now Karpman) 2015-2016</td>
<td>Evaluation of Interventions to Encourage Hepatitis B Vaccination Rate in Patients with Type 2 Diabetes</td>
<td>Implementing travel health pharmacy services, including Yellow Fever vaccine</td>
<td>Hepatitis B calls with Essence/Schucks. MTMs for Essence. Flow chart for nurses.</td>
</tr>
<tr>
<td>Megan Glasheen 2016-2017</td>
<td>Evaluation of the effect of switching to a single tablet tenofovir alafenamide formulation in HIV-infected patients</td>
<td>Med synch to decrease deliveries. Developing a new on-site specialty pharmacy in a new location.</td>
<td>Implementation of patient care notes at the pharmacy in the physician’s office (#304)</td>
</tr>
<tr>
<td>Timothy Ivers 2016-2017</td>
<td>Adherence to Insulin Therapy in the Medicare Coverage Gap</td>
<td>Adding 2 part time or 1 full time technician at store 361</td>
<td>Androgel administration and adherence counseling program</td>
</tr>
<tr>
<td>Katy Kehl 2017-2018</td>
<td>Discontinuation of Medications for HIV Wasting Syndrome</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td>Meredith Voss 2017-2018</td>
<td>Effectiveness of a Monitoring Program for Patients Using Continuous Blood Glucose Monitors</td>
<td>Adding a Monitoring Program for Patients Using Continuous Blood Glucose Monitors</td>
<td>Establishing a Monitoring Program for Patients Using Continuous Blood Glucose Monitors</td>
</tr>
</tbody>
</table>

**Walgreens Pharmacy Resident Projects**

<table>
<thead>
<tr>
<th>Name and Year</th>
<th>Research Project</th>
<th>Business Plan</th>
<th>New or Expanded Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tre’von Elam 2012-2013</td>
<td>The Impact of Specialty Pharmacies on the Health Literacy of HIV-Infected Patients: A Pilot Study</td>
<td>Missouri MOHealthNet MTM program</td>
<td></td>
</tr>
<tr>
<td>Nicole Gibson 2013-2014</td>
<td>Identifying Community Pharmacists’ Readiness to Participate in Transitions of Care</td>
<td>Travel health clinic</td>
<td>MTS protocol for travel immunizations</td>
</tr>
<tr>
<td>Bhumi Gandhi Patel 2014-2015</td>
<td>Impact of Specialty Pharmacy on HIV+ Clinical Outcomes</td>
<td>Medicare Wellness visits. Enhance Travel Health program</td>
<td>“Improving HIV Prevention and Treatment Outcomes Among HIV-Infected Persons by Integrating Community Pharmacists and Clinical Sites into a Model of Patient Centered HIV Care”. She implemented the project and completes MTMs (CMR + TMRs) for patients as part of the program and completes documentation for this CDC program.</td>
</tr>
<tr>
<td>Name</td>
<td>Year</td>
<td>Seminar Topic</td>
<td>Quality Assurance Project</td>
</tr>
<tr>
<td>-----------------------------</td>
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<td>-------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Sophie Willis (now McHardy)</td>
<td>2015-2016</td>
<td>The Role of Community Pharmacy in the Treatment of Patients with Hepatitis C</td>
<td>Prescribing oral contraceptives</td>
</tr>
<tr>
<td>Lauren Lockus Koval</td>
<td>2016-2017</td>
<td>Pharmacist and Physician Perception of Barriers to Collaborative Drug Therapy Management Services in Missouri</td>
<td>PPD testing and reading in the community pharmacy</td>
</tr>
<tr>
<td>Jeffrey Pasucal</td>
<td>2017-2018</td>
<td>Pharmacist involvement in oncology based patient reported side effects in community-based specialty pharmacies</td>
<td>TBD</td>
</tr>
</tbody>
</table>

**Appendix: Resident Seminar, QA and notes (where they went, awards, etc.) by site and year**

### L&S Pharmacy

<table>
<thead>
<tr>
<th>Name</th>
<th>Year</th>
<th>Seminar Topic</th>
<th>Quality Assurance Project</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cassidy Domagalla</td>
<td>2012-2013</td>
<td>Exenatide extended-release: Improving adherence and improving outcomes in patients with diabetes?</td>
<td>n/a</td>
<td>Long term care (LTC)</td>
</tr>
<tr>
<td>Kristen Komaiko (now Niedbalski)</td>
<td>2013-2014</td>
<td>Type 2 diabetes in youth: beyond insulin and metformin</td>
<td>n/a</td>
<td>Stayed with L&amp;S, was a residency preceptor until 2017. Now in pharmacovigilance.</td>
</tr>
<tr>
<td>Emily Hanson (now Milliren)</td>
<td>2014-2015</td>
<td>Prescription Drug Monitoring Programs</td>
<td>n/a</td>
<td>Wrote up seminar and unsuccessfully submitted to JAMA, Ambulatory Care at VA.</td>
</tr>
<tr>
<td>Megan Snodgrass (now Banhart)</td>
<td>2015-2016</td>
<td>Models of Transitional Care</td>
<td>n/a</td>
<td>Initially community and LTC, now clinical pharmacist at U of Kansas Health System</td>
</tr>
<tr>
<td>Alex Majors</td>
<td>2016-2017</td>
<td>The Use of Abuse-Deterrent Opioids in the Management of Chronic Pain: Are They A Safer Option For Patients?</td>
<td>n/a</td>
<td>Received grants from NASPA and GSK for patient care projects. Clinical pharmacist in a health system (Mizzou)</td>
</tr>
<tr>
<td>Bianca Daisy</td>
<td>2017-2018</td>
<td>Use of antimuscarinics in children with asthma</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>

### Schnucks Pharmacy

<table>
<thead>
<tr>
<th>Name</th>
<th>Year</th>
<th>Seminar Topic</th>
<th>Quality Assurance Project</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sarah Essenpreis (now Kay)</td>
<td>2011-2012</td>
<td>HIV Pre-exposure Prophylaxis: The role of antiretroviral therapy</td>
<td>n/a</td>
<td>Now preceptor for students and PGY1 residency at VA and clinical pharmacist. Won presentation merit award for best poster at APhA Annual Meeting.</td>
</tr>
<tr>
<td>Name</td>
<td>Year</td>
<td>Seminar Topic</td>
<td>Quality Assurance Project</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------</td>
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<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mia Davelis</td>
<td>2012-2013</td>
<td>HIV-linked Depression</td>
<td>n/a</td>
<td>Initially in specialty pharmacy, then moved to take position developing MTM program at a PBM</td>
</tr>
<tr>
<td>Ashlee James (now Fadjoh)</td>
<td>2013-2014</td>
<td>What’s love got to do with it? Is HIV linked to an increased risk of myocardial infarction?</td>
<td>n/a</td>
<td>Infusion pharmacist.</td>
</tr>
<tr>
<td>Krista Hein</td>
<td>2014-2015</td>
<td>Cannabidiol Use in Seizures</td>
<td>n/a</td>
<td>Community pharmacist.</td>
</tr>
<tr>
<td>Megan Glasheen</td>
<td>2016-2017</td>
<td>Management of Cardiovascular Disease in HIV-infected Patients</td>
<td>n/a</td>
<td>Schnucks pharmacist</td>
</tr>
<tr>
<td>Timothy Ivers</td>
<td>2016-2017</td>
<td>Hepatitis C in Decompensated Cirrhosis</td>
<td>n/a</td>
<td>Submitted research for publication to JAPhA. Works in specialty.</td>
</tr>
<tr>
<td>Katy Kehl</td>
<td>2017-2018</td>
<td>Initiation of somatropin in HIV positive patients with HIV wasting syndrome</td>
<td>Same as research</td>
<td></td>
</tr>
<tr>
<td>Meredith Voss</td>
<td>2017-2018</td>
<td>CBGM in adults with type 1 diabetes</td>
<td>Same as research</td>
<td></td>
</tr>
</tbody>
</table>

### Walgreens Pharmacy

<table>
<thead>
<tr>
<th>Name</th>
<th>Year</th>
<th>Seminar Topic</th>
<th>Quality Assurance Project</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tre'von Elam</td>
<td>2012-2013</td>
<td>Strivil™ and its Role in HIV Management</td>
<td>n/a</td>
<td>Initially stayed with Walgreens, then moved to Ambulatory care at VA.</td>
</tr>
<tr>
<td>Nicole Gibson</td>
<td>2013-2014</td>
<td>The Role of Sofosbuvir in the Treatment of Hepatitis C</td>
<td>n/a</td>
<td>Published research. Works in specialty.</td>
</tr>
<tr>
<td>Sophie Willis (now McHardy)</td>
<td>2015-2016</td>
<td>Hepatitis C Genotype 3</td>
<td>n/a</td>
<td>Specialty pharmacist with Walgreens</td>
</tr>
<tr>
<td>Lauren Lockus Koval</td>
<td>2016-2017</td>
<td>ADHD treatment in adults</td>
<td>n/a</td>
<td>Received an APhA Incentive grant and a STLCOP Faculty Incentive Research grant. Patient care expansion now available company-wide. Walgreens specialty pharmacist and residency preceptor in training.</td>
</tr>
<tr>
<td>Jeffrey Pasucal</td>
<td>2017-2018</td>
<td>Depression in the Elderly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>