HOW TO START
A RESIDENCY PROGRAM

WHAT YOU REALLY NEED TO KNOW

OVERVIEW

The following information will describe several factors to consider and act upon in starting a residency program. Each aspect of program development will be reviewed and specific, practical steps will be given to enable the reader to implement a new residency program. Starting a residency program is a multi-year endeavor that requires both program organization and cultivation of widespread support from various groups within the specific practice site. Therefore, this information is organized around these two major activities. Section I describes program organization from inception through recruiting. Section II addresses the target groups needed for support and strategies to use for each one. Finally, Section III attempts to tie all of the information together in a discussion of some of the "nuts and bolts" of the accreditation process. This information is provided to assist you in overall residency program development. It cannot address all the nuances that may arise during program development. If something comes up that is not covered, we recommend that you refer to residency regulations and standards, Best Practices for Health-System Pharmacy[1], or direct questions to the Accreditation Services Division (ASD) at the American Society of Health-System Pharmacists. ASD staff members are available to answer questions and assist you in your residency program development.

Starting a residency program is a significant undertaking requiring a lot of hard work. However, the end result will be one of the most professionally rewarding experiences achievable.

CREDITS

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SECTION I -- STARTING A RESIDENCY PROGRAM

This section is divided into five topics, each following chronologically, for initiating a residency program. There is significant overlap between the topics, which are:

A. Initial Assessment
B. Early Decisions
C. Resources
D. Program Design
E. Recruiting

These topics vary greatly in the time and effort required for completion.

A. Initial Assessment

The most fundamental step in initiating a residency program is determining if the necessary elements for training practitioners are present at the practice site(s). The best place to start is to read the American Society of Health-System Pharmacists (ASHP) *Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs*[2]. Even if this standard does not apply to the residency being planned, the concepts within it will be valuable for evaluating the readiness of the practice site. The standard is not particularly long or technical. Nonetheless, it is best to read it through a few times and contemplate the requirements set forth; there is much to learn from it that may not be readily apparent.

One of the most important concepts presented by the standard is that pharmacists must be trained by other pharmacists. This is not to understate the importance of physicians, nurses, and other healthcare practitioners who contribute to a complete training experience, but the most central and material training and preceptorship for residents must come from pharmacist practitioners. Therefore, in reviewing the learning experiences that would make up the majority of the residency program, it is helpful to ask if these will be predominantly temporary situational experiences or whether they will be part of an ongoing activity in an actual practice environment.

Temporary situational experiences are those in which a pharmacist is temporarily placed in a practice setting to serve as preceptor for the duration of the residency training experience or rotation, and then is removed. Another example is when a pharmacist is preceptor to a training experience in name only, but in fact another practitioner (e.g., a physician) serves as the primary preceptor. In either case, residents are not participating in a true pharmacy practice experience from which concepts and mechanics of pharmacy practice can be acquired. These scenarios are different from the actual continuing practice experience where residents "plug-in" to an ongoing pharmacist's practice for the purpose of learning experiences.

This is not to say that temporary experiences should never be used for residency training. On the contrary, sometimes they are very useful. However, these experiences should not be used as the predominant method of training pharmacy residents.

The initial assessment of the readiness of the program is an excellent opportunity to bring together key pharmacists who will be major contributors in the residency program. The assessment is more meaningful if done as a group effort. The goal is to honestly identify deficiencies that need to be addressed. Do not let this exercise become discouraging. Remember that at this point it will probably be two or three years before a resident is actually present "in the flesh," expecting to enter into any particular learning experience. There will be ample time to address any deficiencies that are identified.

B. Early Decisions

As part of the initial assessment, some specific questions should be answered:

How many resident positions should there be initially?

Although most programs have started out with one resident, it is best to start with at least two. This is a very manageable size, but it makes the program more diverse. Also, it can be difficult for a resident to go through a residency alone. Having at least one peer can be extremely helpful in the learning experience.

Should the program be college affiliated?

Wherever a residency program is developing there is most likely a college of pharmacy that would be interested in some degree of affiliation. The pros and cons of such an affiliation must be weighed by the program director in light of the accreditation standard and the unique set of circumstances surrounding the residency program. However, this decision is often overlooked in the initial planning stages. There are substantial benefits to college affiliation for any residency program and it is important that these potential benefits be duly considered.

Should the program be accredited?

Accreditation of pharmacy residencies is currently provided exclusively by ASHP through their Commission on Credentialing. Pursuit of formal accreditation is no easy undertaking. The value, however, is significant. Following are some reasons accreditation adds value to the program:

1. The willingness of any program to submit to outside peer review speaks highly of the commitment to excellence in residency training. It is easy for a program to achieve high performance and then stagnate in some aspects, primarily due to successes of the past. By putting the program through periodic written evaluations and site surveys, stagnation can be avoided. The accreditation process is a continuous quality improvement process that cannot be reproduced internally.

2. ASHP is a tremendous resource to residency program directors and preceptors, both in initiating and in actually implementing a program. Pursuit of accreditation makes all these resources available. ASHP provides staff in the Accreditation Services Division (ASD) who are experts on residency training programs. Pertinent information regarding critical issues in residency training, a match program for selecting residency candidates, and opportunities for networking with other residency preceptors are among the resources provided by ASD staff members.

3. One major value to a new program pursuing accreditation that is not readily apparent is the positive effect within your practice setting. As applicable, physicians, nursing leadership, administration, and pharmacists themselves will view the program with greater credibility knowing that formal accreditation is involved. The accreditation process provides a forum for formal and informal discussions about the residency program with key people throughout the practice site. This is a great opportunity to promote the program to a wide variety of decision makers. Physicians can especially identify with the accreditation process since they probably have also completed a residency and they understand the importance of national accreditation. The effect that pursuing accreditation can have on how the residency program is received can be profound.

The decision to pursue accreditation is a big one and should be made as early as possible in the planning efforts. For the purposes of the following information it is assumed that accreditation will be sought for the new residency program.

What is the primary purpose of the residency program?

The purposes of residency programs vary greatly. Each program should have a statement to communicate its purpose. The purpose statement of the program should be general to allow for the development of individual goals for each participating resident. Picturing the product desired as a result of the residency experience will help in writing the overall purpose. Will most graduates of the program be practitioners in acute care settings, be practitioners in ambulatory care settings, pursue a postgraduate year two (PGY2) pharmacy residency in a specialized area, or seek academic appointments, etc.? The program's purpose statement should emphasize the unique strengths of the pharmacy program. For example, it would not be prudent to establish a purpose statement about developing strong research skills in the residency if the practice setting does not engage in clinical research. The program's purpose should be reviewed yearly, but is not likely to change significantly over time.

C. Resources

ASHP Staff: As mentioned earlier, the most valuable resource available for developing a residency program is ASHP's Accreditation Services Division staff. As you begin your planning, you should contact one of the ASD staff to discuss requirements of the accreditation standard and the development of your program. At both the ASHP Midyear Clinical Meeting and the National Pharmacy Preceptors Conference, sessions are offered for all new and prospective preceptors to

discuss the "nuts and bolts" of starting a residency. Attendance at one of these sessions is highly recommended, especially a Residency Learning System (RLS) workshop (more about the RLS Model later in Section III B and C).

In addition to the RLS workshops conducted at some national pharmacy meetings, ASHP Accreditation Services Division staff may be available to conduct on-site, local workshops in either a half-day or all day format. Please contact ASD staff for availability and associated costs.

The ASD staff is committed to helping new residency programs achieve a successful outcome. These pharmacists are valuable members of the development team.

ResiTrak®: A value added, web-based tool provided at no cost to all programs in the ASHP accreditation process to assist with program design, record-keeping/documentation, evaluation of residents, and residents' evaluation of the program. Designed and maintained by the McCreadie Group, ASHP's contractor, the program does not require installation of any software, allows customization of residencies, and helps programs provide a systematic approach to residency training.

Consultants: Consultants are another available resource. Individuals who have participated in the start-up of residency programs and have served on the Commission on Credentialing are uniquely suited for this role. The ASD staff can provide a list of qualified individuals. Consultants should be paid a fee for their services, including travel expenses if necessary.

A variety of other resources are available to new programs. For example, other program directors of active residency programs are often very willing to share information and documents that will be helpful in this effort. Again, the ASD staff can facilitate the networking opportunities for a new program. The program's own pharmacists who have completed a residency or have practiced in a setting where residency training was conducted will have insights and suggestions applicable to the planning process.

The resources described above are essential for developing a new program. It is very difficult to achieve success without the use of some, if not all, of these resources.

D. Program Design

Types of Experiences: Program design will consume the most effort in developing a new residency. Historically, residents' learning experiences have been formatted almost exclusively into monthly rotations. Although this modality is still used extensively, there are currently a number of types of learning experiences woven into a residency program. Since the majority of programs are 12 months in length, the opportunity for participating in different types of experiences is extensive. Learning experiences in residencies can be categorized into the following general types: rotational, extended, longitudinal, and concentrated.

Rotational learning experiences are typically four, five, or six weeks in length and are associated with a particular specialty or primary aspect of pharmacy practice. These experiences are usually used for both required and elective rotations. The number of required versus elective rotations varies widely from program to program. For example, rotations may be required in various areas, such as ambulatory care, general medicine, infectious diseases, and critical care. Residents may decide to take elective rotations in cardiology, oncology, nutrition, or practice management, or to repeat aspects of required rotations as advanced experiences. A limitation of rotational experiences is that many learning opportunities do not fit neatly into one month.

Extended learning experiences are typically six to eight weeks in duration and are usually spent with the same preceptor. In this type of learning experience residents have time to build confidence in the practice area. It offers sufficient practice time to develop independent problem-solving skills, facilitates preceptor/resident bonding, and provides sufficient time in place to enable teaching. There is also sufficient time in place to assess growth in skills and to promote skills in integrating practice. In addition, patterns of practice become evident. However, this type of learning experience limits the number of patient populations with which residents can work and residents' schedules may be out of synchronization with students and medical residents.

Longitudinal learning experiences are those that extend over a significant portion (e.g., 3, 6, 9, or 12 months) of the residency year. They are ongoing and might not be associated with one particular service or patient care area. Examples of longitudinal learning experiences are pharmacy administration/management, the residents' major project, and staffing (or service commitment). Other areas, such as ambulatory care, can be either rotational or longitudinal, or a combination of both. With the latter approach, residents are responsible for a group of patients throughout the entire year. Residents maintain follow-up from inpatient admission, through discharge, and during ambulatory care. It will be difficult to provide a complete learning experience in ambulatory care if it is viewed only as one of many rotational experiences. Ambulatory patients often have long-term medical needs that cannot be appreciated in a short learning experience.

Concentrated learning experiences are those that occur once in the program and may not be seen again until the next year. Budget preparation, cardiopulmonary resuscitation training, travel experiences, interdepartmental visits, and community service projects are examples of concentrated learning experiences.

Two vitally important items establish these modalities of training as true learning experiences: learning objectives and evaluations.

Learning Objectives: Every learning experience should be associated with a set of learning objectives. Developing learning objectives may sound like an overwhelming task. However, ASHP has invested significant resources in developing model educational goals and objectives for use in any accredited program. For postgraduate year one (PGY1) pharmacy residencies, these goals and objectives may be obtained from the ASHP website at www.ashp.org. Also, numerous other sets of educational goals and objectives for PGY2 pharmacy residencies in various specialized areas or

settings have been developed and are posted on the ASHP website. It is best to avoid getting bogged down trying to make the perfect selection of goals and objectives for all learning experiences. Objectives are dynamic to start with and, therefore, will be changed as time goes on. Start with a functional set for each learning experience and then refine them over time with input from preceptors and residents.

Evaluation: Frequent, ongoing evaluation (or assessment) is the hallmark of a good residency program. Residents should be evaluated in all their learning experiences. Residents should also be expected to evaluate themselves, their preceptors, and the strengths and weaknesses of each aspect of the program. A host of forms and instruments for conducting these evaluations exist across the country through accredited programs. It is important to take advantage of these tried-and-true tools rather than starting from scratch. Evaluation tools have also been developed by ASHP as part of *The Residency Learning System (RLS) Model*[3].

Service Commitment: One often-questioned aspect of program design is the service commitment (staffing component) and how it relates to the residency experience. The service commitment should be viewed as providing essential services to patients. These could range from drug distribution activities to specific therapeutic drug monitoring and patient consulting activities. Staffing various areas of the pharmacy service may be a valuable developmental experience for residents, provided certain conditions are met:

- the service commitment is not the major focus of the residency,
- the service commitment's scope is defined and firm time requirements are set,
- learning objectives associated with the service commitment are established and relevant, and
- regular evaluations of residents' performance during the service commitment learning experience are completed.

With the above features in place and a description of the value of the requirement provided, residents rarely have any lasting concerns regarding this aspect of the program. The Commission on Credentialing will also wholeheartedly support such an arrangement.

Training Manual: The "road map" of the residency program is the training manual you develop for your residents. This document is usually in a three-ring binder format. It is helpful to obtain manuals from other programs and use their best features in creating one customized for your program. Much of the program design particulars should be included in the training manual. Some of these particulars include:

- policies describing leave time options, requests for changes to established learning experiences, key pharmacy standards, etc.
- an overview describing the general services of the pharmacy and how residents fit into them.
- a description of the residency organization detailing to whom residents report for activities in which they are involved.
- schedules showing how a typical resident's year is laid out.
- benefits associated with the residency; e.g., sick leave, annual leave, holidays.

- travel requirements of the program and expenses that will be covered by the training site.
- descriptions of both required and elective learning experiences, including educational outcomes, goals, and objectives for each.

Many other items can, and should, be included in the training manual. Anything that is pertinent to the program is appropriate. During the first day of a new resident's orientation this training manual will be helpful in guiding the initial walk-through of the overall program.

Project: One last, often challenging aspect of a program's design is the requirement that residents complete a project. The most difficult part of planning for a project is determining and describing the appropriate size and scope. Draw from the experiences of other programs in determining how to proceed. A true clinical research project is beyond the scope of a 12 month residency. There are, however, many types of meaningful projects (or portions of a clinical research project) that will contribute significantly to residents' skill as a practitioner.

E. Recruiting

Finding Candidates: Preparing for recruiting new residents should begin early in the planning process. It would be discouraging to go this far and not have anyone enter the program. ASHP is effective in getting the word out about programs in pre-candidate status (those programs that do not have residents in training). They will assist in getting information about these programs into the on-line ASHP *Residency Directory*[4] (which is reviewed closely by pharmacy students) and in getting programs registered for the Residency Showcase at the Midyear Clinical Meeting.

The Residency Showcase is a very important event in recruiting. In addition to being exposed to huge numbers of residency candidates, preceptors in attendance may also become aware that there is a new residency available. They in turn will often become a source of referral for candidates who are seeking a residency in specific geographical areas. The Residency Showcase also allows new programs to see what other programs are doing and provides an opportunity to share ideas.

It is important to note that all programs in the accreditation process (pre-candidate status, candidate status, accredited, etc.) must participate in the Resident Matching Program (RMP). The RMP coordinates placement of residents in residency programs.

All programs in the accreditation process also have the option of using the Pharmacy Online Residency Centralized Application Service (PhORCAS®) to receive candidates' applications electronically. PhORCAS® is a web-based tool that brings application materials together in one location, streamlining the recruitment process and reducing the administrative burden that would otherwise come with paper applications.

For the first year, it is often effective to look for candidates close to home. Eliminating major relocation issues faced by candidates may reduce the complexity of making a final choice. The local colleges of pharmacy may be one place to be plugged-in to find such candidates. Many colleges have a Career Day or, better yet, a Residency Showcase Day. These are events not to be missed when on

the recruiting trail! Frequently, some of the most promising prospects for a new program arise after the RMP is complete. An excellent resource is a list of unmatched candidates available from the ASD division at ASHP -- a roster of all the students who want to do a residency, but have not secured a position through the RMP. In addition, some of the best residency candidates are among those students who, after the RMP deadline, decide that they want to pursue a residency. Finding out who these folks are can be difficult but may be a great opportunity for successful recruiting. The key to successful recruiting, however, is to start early.

What are some selling points of a new residency program to a potential candidate? First, it is important to inform candidates that formal accreditation proceedings are under way with ASHP. This will convey a strong sense of the commitment the practice site has to the new program. To the same end, it is valuable to describe efforts that have been put forth in bringing the program to its current status. Describing how the program is laid out and the various experiences planned will give candidates an idea of how effectively it is organized and whether it will provide a meaningful training experience. This information will allay concerns residency candidates may have about graduating from an unaccredited program. Be sure candidates understand that once accreditation is gained it becomes retroactive to the date the application was filed with ASHP and, therefore after notification from ASHP that the program has achieved accredited status, the program director may provide residents in the program at the time of application with a certificate indicating completion of an ASHP-accredited residency.

One of most outstanding and unique opportunities associated with a new program is the chance for the residents to actively develop many aspects of the residency. This learning experience, so valuable to their careers, only comes along once in the lifetime of any residency program. Be sure to point out this rare opportunity.

SECTION II -- DEVELOPING SUPPORT

This section will provide specific strategies for developing widespread support for the residency program from key areas within the practice setting. These efforts occur simultaneously with the activities described in Section I. The roles of pharmacy staff, physicians, nurses, and administrators will be discussed. Each plays a significant role in the success of the program. Pharmacy staff will support residents through their training. In applicable settings, physicians and nurses will facilitate residents' welcome into the clinical team, and nursing staff will provide residents with accessibility to patient care areas. Administration will provide the ongoing financial means to fund the residency program. Obtaining a strong commitment from all parties is a long-term endeavor that requires continued effort, but provides lasting results.

TARGET GROUPS

A. Pharmacy Staff
B. Physicians
C. Nurses
D. Administration

Pharmacy Staff:

Pharmacists, et al: The support of this group is paramount to the success of the residency. Everyone should be part of the process and aware of the program's goals from the earliest planning stages. Do not assume that everyone is familiar with residencies and what they are all about. There needs to be a planned, widespread education process to bring all pharmacy staff up to date on the value of offering a residency program and the unique status of residents who function both as licensed pharmacists and postgraduate students. Residents will learn from everyone in every aspect of the pharmacy operation. Pharmacists will guide them in the practice of pharmacy, technicians will teach them how to operate the computer and automated medication dispensing cabinets, secretaries will help them get presentations and papers prepared, and on and on. With residency training, there truly is something for everyone in the pharmacy to get involved in. The residency is most productive when the pharmacy's attitude toward the residency program is one of ownership.

It is important to keep everyone updated regularly on the progress of program design, recruiting, discussions with ASHP, etc. One way to assist this process is to establish a residency program committee. This committee of individuals from various pharmacy practice areas can develop, review, and monitor activities throughout the course of the program. In addition, they can serve as the core group to inform others of progress in the program. Keeping everyone completely informed about the program will increase the likelihood of a successful accreditation site survey.

B. Physicians

Physicians: The opportunity to work with residents will have innate appeal to most physicians. Although not all physicians may want to be academic faculty, almost all genuinely enjoy the opportunity to teach now and then. This is a great opportunity for collaboration to plan and implement the learning experiences, particularly those in the clinical areas. Take advantage of every opportunity to share with physicians the process that is being followed to start the program and get it accredited. Where they are utilized, the Pharmacy and Therapeutics Committee is an excellent forum for presenting this information. Be prepared for some physicians to ask what a pharmacy residency is all about. A short, meaningful answer is best. Relating it to medical residency training can provide a common reference point.

It is easy to underestimate how well physicians will identify with the accreditation process. Most of them are aware of the accreditation status of the residencies they completed and how important this is to the quality of training. If the pharmacy residency is being developed in an institution where medical residencies are also offered, the medical staff's understanding will be even more extensive. Be sure to follow up with physicians on successes, such as securing the first candidates for the program and the outcome of the accreditation process. It is a good idea to specifically thank the physicians who work directly with residents in the first year for giving their time and taking interest in the training experience.

C. Nurses

Nurses: Nurses readily recognize many positive aspects of a pharmacy residency. Like physicians, most nurses enjoy the opportunity to teach. Residents learn a great deal from nurses about such topics such as drug administration, patient/family issues, and general patient monitoring. Having residents brings direct value to both nurses and patient care (which nurses will also see as positive). Residents will be available to provide nursing education and inservice training on drug therapy topics. They will also be available to provide a considerable amount of drug information and patient-specific drug therapy consultation to enhance patient care and support the practicing nurse. Because of the residency program, new and improved pharmacy services will be evaluated and implemented. Residents will collaborate with nurses in areas of quality improvement, patient education, and drug use control. In some of these areas, residents will be able to participate where pharmacists have not done so before. Often, previously closed doors are opened in the name of education.

As with physicians, it is important to keep nurses updated on the status and progress of the program's development. Nurses will also participate in the accreditation process. Notes of appreciation for their support in the first year of training are appropriate and effective.

D. Administration

Executives: Administrative leadership should be involved from initial concept through residency program development. The commitment of administrators is paramount. In fact, ASHP corresponds directly with the site's chief executive officer (CEO) or equivalent regarding all issues of accreditation. One of the early concepts to establish with administrators is that this is a long-term endeavor. Trying a residency as a pilot program is not practical. Residencies improve and gain momentum year after year, and it is unrealistic to just "stick your toe in the water."

Pharmacy residencies add a genuine value to the practice site. Among benefits are the following:

- a site offering a pharmacy residency program is part of an elite group. Only around 1500 residency programs exist in the country and only those with excellent health care services are accredited;

- residents will contribute significantly in carrying on those activities necessary for The Joint Commission, American Osteopathic Association (AOA), National Council for Quality Assurance (NCQA), or other agency's accreditation and for continuous quality improvement;

- physicians will view the program in a positive manner;

- the pharmacy staff will be gratified to be a part of such a program.

Funding: One of the primary concerns of any administrator is how the program is going to be funded. A variety of strategies can be used for funding resident positions, including:

1. Cost-impact analysis of a residency program can offset the program's expenses. If the site is facing inevitable expenses for meeting nationally applied practice and operational standards or providing patient education, a pharmacy residency program may meet the needs at less expense than other alternatives.

2. Splitting one pharmacist position into two residency positions will usually yield leftover dollars. If residents fulfill a service commitment (staffing) on a routine basis (e.g., every other weekend) the pharmacist who comes off those shifts will be more available during the week. With some rearranging of responsibilities the net loss is zero and the residency is funded by internal dollars.

3. New services being planned and/or already approved that will require additional staff are an opportunity to include resident rather than pharmacist positions. Any new plans should be evaluated as to the cost effectiveness of including resident positions.

4. In acute care sites treating these patient categories, Medicare and Medicaid allow for pass-through graduate medical education costs in the overall cost formula for the site. PGY1 pharmacy residencies that are accredited by ASHP qualify under guidance for allied health education programs. These pass-through dollars can be significant. At many sites these dollars actually offset all the costs of having a residency. If a site does not have medical residents, then the finance staff may not be familiar with how to maximize these reimbursement dollars. ASHP can help the pharmacy staff obtain more detailed information. (See also: *Understanding Reimbursement for Pharmacy Residents*[5].)

5. External funding, either total or partial, may be available from a variety of sources, such as colleges of pharmacy, the pharmaceutical industry, a local physicians' foundation, a wholesale company serving as the prime vendor, and others. If future healthcare financial reform reduces or eliminates the reimbursement avenue described in number four, above, then external funding will become even more common.

It is important to share with administrators the other direct costs associated with a residency program in addition to salaries. Monies should be budgeted for residents' travel (state and national meetings of professional pharmacy associations, the regional residents/preceptors conference, etc.), books/periodicals, recruiting expenses, and ASHP fees (application fee, accreditation annual fee, and Residency Showcase fee).

Once approved, it is vital to keep administrators abreast of the progress of the program. After the program is operational, take opportunities to share anecdotes about residents’ successful activities. After the first year of the program include a special addendum to the pharmacy's annual report entitled "The Value of the Residency" that recaps the financial, operational, and patient care impact of the program. It is wise to include something positive and tangible regarding the residency in every annual report.

SECTION III -- ACCREDITATION

This section is divided into five topics that follow the course of accreditation. There is significant overlap between topics, which are:

A. Accreditation Process
B. Accreditation Standard
C. Structure and Conduct of the Residency
D. Experimentation and Innovation
E. After the Survey

A. Accreditation Process

Purpose: ASHP has served as an accrediting body for pharmacy residency programs since 1963. Accreditation provides a measure of quality for current residents and prospective candidates seeking a residency program. Employers who hire residents from accredited programs are assured that the residents have received training in providing direct patient care. The accreditation process ensures that residents have received an experience consistent with the standards of practice.

Residency accreditation focuses on pharmacy services offered to patients, and the residents and their training program.

To maintain quality, a formal mechanism should be in place to evaluate residency applicants. The evaluation should examine the individual's credentials, qualifications, and fit with the practice setting. This activity should be documented. It is important to ensure that the residency candidate has sufficient formal education and clinical background, and will be able to apply them during the residency.

Application: The residency program must have at least one resident in training to apply for candidate status (accreditation). Applying for candidate status involves completing a two-page application and submitting it to ASD with a copy of the residency program director's Academic and Professional Record form and curriculum vita. However, prior to the site survey the program is required to complete a presurvey questionnaire provided by ASHP. Be sure to start early because completing the presurvey questionnaire is time consuming. The questionnaire coincides with the accreditation standard in list form. The left side of the document is a description of the applicable standard; the right side is used to note the level of compliance with the standard. Levels of compliance are defined as full compliance, partial compliance, noncompliance, or not applicable.

The pre-survey questionnaire may require significant supporting documentation and attachments, such as a copy of the residency program's promotional materials and copies of goals, objectives, and evaluations. Over 20 supporting documents are requested.

The presurvey questionnaire is an excellent tool to prepare for the survey since it will alert you to any areas of noncompliance prior to the site visit. It will also serve as an ideal framework for an annual evaluation process. The questionnaire is used to maximize the effectiveness and efficiency of the ASHP accreditation team when conducting a site interview. Completed questionnaires are submitted to the Accreditation Services Division of ASHP 45 days before the survey. Take time during this portion of the process to ensure that you are meeting the intent of the accreditation standards and to make necessary changes. Seek recommendations from others who have recently been through the survey process and from the ASD staff to improve the program.

In the application process, using a consultant may be an excellent way to obtain recommendations. By getting multiple people involved in the process, you should be able to identify areas of weakness and discuss possible solutions with residents, preceptors, and other colleagues. As mentioned previously, ASD staff and members of the Commission on Credentialing serve as excellent resources.

Site Survey: The survey team consists of at least two people. One is a member of the ASD staff and the other is a member of the ASHP Commission on Credentialing or other competent pharmacist/leader in the field. If you have multiple programs (e.g., PGY1 and PGY2 programs) additional surveyors who have expertise in the practice area being surveyed will be on the team. The survey team is on a fact-finding mission. Throughout the survey the team poses questions, listens to those involved, and reviews documents.

Residents should participate in all aspects of the survey process. This is a learning experience for them (as well as for the first-time residency director) and should provide good insight into the role and purpose of accreditation.

The survey usually occurs over two full days or one full day and two half days. The survey team will visit multiple areas of the practice site, when applicable (e.g., nursing stations, decentralized pharmacy locations, and the emergency room). Interviews will be scheduled with physicians, nurses, residents, and preceptors. The process is intended to be thorough, consultative, and educational. The team looks for common threads to demonstrate that residents are being taught an integrated approach to patient care.

Upon completion of the survey, the survey team will conduct a closing interview with members of the pharmacy, including the residency program director and director of pharmacy. The purpose of this meeting is to outline areas of deficiency and needed improvement. Areas of strength and innovation are also discussed at this time. These recommendations are then forwarded to the ASHP Commission on Credentialing for approval.

A final interview is conducted with the site's CEO or designated administrator. Remember, support at this level is important to the residency program. Accreditation-related official correspondence is copied to the CEO of the practice setting.

Existing Programs: If you have a residency program and are facing reaccreditation in the near future, you are aware that the process can occur before you know it. A site visit occurs every six years. Early preparation is important and will ensure that there is ample time to complete a detailed program assessment.

Annual Program Assessment: Just as the survey process is cyclical, it is recommended that an ongoing annual assessment take place. As a result of this assessment, the program not only prepares for the imminent accreditation visit but also brings change, growth, and development. The annual assessment should include a variety of formal and informal mechanisms throughout the residency year. The primary goal of an annual assessment is to actively improve the program and seek out ways to respond to residents' needs. The best opportunity for assessment comes through the residents' feedback. Preceptors should encourage residents to regularly discuss the program and make suggestions. If you incorporate an open door policy into the residency, it will provide a source of constant, honest information from residents.

Program changes and ideas for growth can also be solicited informally through preceptors, physicians, nurses, administrators, pharmacy managers, and others associated with the residency program.

Residents' monthly written evaluations provide a regular and formal program assessment tool. The information gathered through these evaluations about preceptors and training experiences should be used continuously to improve the program's format and content.

An anonymous group evaluation completed by residents before they leave the program provides another opportunity for assessment. A group of residents who have had the opportunity to express issues and concerns throughout the program will produce an evaluation with no surprises. New information provided in this process may mean that additional program evaluation mechanisms are needed.

Another source of information for the annual assessment can occur through quarterly preceptor meetings, which provide an opportunity for preceptors to communicate, make mid-course corrections, or simply compare experiences.

Program Growth and Development: A second goal accomplished through an annual assessment is program growth and development. Each comment that surfaces as a result of a completed program assessment should identify opportunities for program change. An example of program growth is the development of new residency experiences, perhaps as a result of collaborative relationships with universities, health-systems, community pharmacies, home care agencies, etc. Assessments may also identify the need for increased numbers of residents or preceptors. Additionally, opportunities for growth in preceptors' personal teaching styles and methods can be identified.

Information Resources: The ASD staff and those who attend national preceptor training programs, regional residency conferences, and Residency Learning System (RLS) workshops serve as excellent resources, as do outside consultants.

B. Accreditation Standard

Standards: Let us review for a moment the *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs*[2], approved in September 2005.

It is possible that even an existing accredited residency program will not meet the requirements of a new accreditation standard. Program adjustments may be needed to meet the full interpretation of the standard. The standard is complex and will require detailed study. Take the time to read the standard and interpretations several times.

A major principle outlined in the standard is the requirement that you design, develop, conduct, and evaluate residents' training using a systematic approach. For that purpose ASHP has provided *The Residency Learning System (RLS) Model*[4].

Learning Experiences: There are six required educational outcomes in which residents must receive instruction and develop competence. Specifically, residents will be held responsible and accountable for acquiring these outcome competencies: managing and improving the medication-use process; providing evidence-based, patient-centered medication therapy management with interdisciplinary teams; exercising leadership and practice management; demonstrating project management skills; providing medication and practice-related education/training; and utilizing medical informatics. Each area must be covered during every resident's program using a combination of experiences, as previously described. The residency director may choose to use longitudinal learning experiences in these areas over the year or separate the experiences into individual training blocks to meet both the program's and residents' objectives.

Planning residency program experiences requires care. A balance must be achieved to allow sufficient time for residents to meet the required program outcomes without becoming frustrated or confused.

Separate experiences, such as rotations, offer the structure to ensure educational outcomes, goals, and objectives are met but, unfortunately, they may not mimic the real practice environment that the resident will soon face.

Most residency directors integrate some experiences throughout the training year while separating others into definite time periods. The system used to provide experiences in all six required outcome competencies should meet residents' needs and previous experience. Again, the RLS provides a model system you may wish to use. Examples of integrated and separate training experiences are provided in the following descriptions of three of the required outcomes.

The Required Outcomes: Examples of activities and responsibilities for three of the required outcomes outlined in the standard, are:

1. **Provide evidence-based, patient-centered medication therapy management with interdisciplinary teams.** To completely understand this area, which covers a wide range of patient care activities, applicable documents from *Best Practices for Health-System Pharmacy*[1] (e.g., *ASHP Guidelines on a Standardized Method for Pharmaceutical Care, ASHP Guidelines: Minimum Standard for Pharmaceutical Services in Ambulatory Care)* should be reviewed. This area of the residency accreditation standard is written to require training of practitioners for providing care to patients with acute, subacute, or ambulatory needs. Resident activities in the patient care area might include interdisciplinary rounds, patient education, and therapeutic drug monitoring.

   The standard states that preceptors must practice in the area that residents use as an educational site. Residents need to work directly with preceptors to have the opportunity to emulate appropriate role models. At least in initial stages of training, attendance with residents on rounds or in team meetings is essential to ensure that residents use the tools available to make rational clinical decisions. In this regard, skill with one important tool, the provision of drug information in support of patient care, is a necessity. Thus, residents entering training without this skill set may need instruction in the theory, organization, and practical application of an organized program of drug information services in support of patient care.

   In designing patient care activities, the emphasis should be on the provision of care to all patients. The residency site should strive to provide core services to patients even when residents are not present. Residents can be introduced to specialized services for patients who will benefit the most but should not spend a majority of the time in specialized activities unless that is the only patient population served by the residency site (e.g., a children's hospital).

   Longitudinal, extended, and rotational learning experiences can be used for the patient care component of the residency. Rotations, for example, provide more focused experiences and, when appropriate (e.g., for ambulatory care) can be coupled with longitudinal activities.

   In addition to traditional outpatient experiences in clinics and community pharmacies, examples of ambulatory patient care areas you may be able to seek out for training include home health care pharmacy, disease state management programs, medication compliance monitoring, and wellness or health promotion.

   The standard requires experiences where residents work with the same patient or group of patients on repeated visits. The concept is to provide a continuum of care that can take the patient from the inpatient to the ambulatory or outpatient setting. Again, the standard asks that the same level of services be provided to all patients.

   Longitudinal learning experiences are often used in ambulatory patient care areas so the resident is able to work with the same patient on repeated visits.

2. **Exercise leadership and practice management skills.** The purpose of this required competency area is to show residents the importance of determining the overall direction and integration of pharmacy services. It also is where residents should learn about the day-to-day requirements needed to manage pharmacy activities. Another purpose of this area is to provide theory to residents on topics such as formulary management, drug use control, and medication errors. Once residents are introduced to the organization of these topics, they need to apply them to actual practice and projects. A spectrum of other experiences can also be used to ensure that drug information principles are incorporated into residents' training, such as participating in the Pharmacy and Therapeutics Committee activities (medication error and adverse event reporting), evaluating new drugs for formulary addition, making journal article presentations, and conducting therapeutic class reviews. Learning about the policies and procedures associated with investigational drugs is also an important activity that can be incorporated into this area. You may choose to provide unique opportunities for practice management and leadership development or integrate longitudinal learning experiences throughout the year.

   Residents need to understand why decisions are made involving budgets, staffing, and program development. Planning for these decisions may occur only once in an annual cycle, so it is important to include residents during these key times. Participation in discussions that result in decisions and knowing the reasoning behind the decisions are key factors in meeting the intent of the accreditation standard.

3. **Demonstrate project management skills.** Completion of an appropriate project, an investigation of some particular element of pharmacy, is another required educational outcome. Projects must be directed toward useful outcomes and should not be mere academic exercises for the sole purpose of satisfying this requirement. They may be in the form of original research, a problem-solving exercise, or development, enhancement or evaluation of some aspect of pharmacy operations or patient care services.

   Residents will be required to make a formal presentation of results obtained through the project and to submit a final report, following an accepted manuscript style.

C. Structure and Conduct of the Residency

Experience: The best residency experience is one that is planned, organized, and systematic. The residency experience needs to be mapped out using real activities and problems. Preceptors walk a fine line in leading new practitioners through real practice problems until they have become experienced residents.

The Residency Learning System (RLS) Model[3]**:** The residency road map is best developed by utilizing the program design process included in the previously mentioned RLS Model and associated RLS tools, and RLS workshops conducted by ASD. As you know from prior discussion in this document, residency program directors are encouraged to use the methodologies outlined in the RLS Model.

D. Experimentation and Innovation

The Commission on Credentialing encourages ongoing innovation in the design and conduct of training. The intent is to encourage residency directors to try new ideas and explore uncharted territory. Activities that can be included in this are limited only by the imagination. Possibilities include the development of new services and funding sources. While experimenting is encouraged, check with ASD staff, available consultants, and the residents involved. This will help you avoid training contrary to the accreditation standards and may alert you to similar efforts made elsewhere.

E. After the Survey

Once the accreditation survey is completed, the residency site is ready to look for opportunities for program growth and development that have been identified through the presurvey questionnaire and site survey. As the program changes, yet another set of needs will be identified and the cycle will repeat itself.

The direction you offer through the residency program will prepare tomorrow's leaders. These individuals will be future clinical specialists, college faculty, pharmacoeconomists, pharmacy managers, and patient care managers. As a fortune cookie message explains, "You are often unaware of the effect you have on others."

CONCLUSION

Starting a residency program is a demanding undertaking. However, there are many willing and able colleagues available to assist in the effort. The ASD staff and the Commission on Credentialing want sincerely to see residency programs succeed and grow in number. They will support the development and continuation of a new residency program in every way possible.

The impact of a residency program on a practice site and the pharmacy is profound. Once the residency is implemented, the staff will find that the quality of, and the pride associated with, the services they provide are irreversibly enhanced. The pharmacy program will be viewed in a broader context throughout the practice setting. And the sense of accomplishment in achieving accreditation is great.

However, the most compelling experience of being associated with a residency program will be the chance to contribute to the growth and development of young and eager pharmacists. Watching newly graduated pharmacists enter the program and exit one year later as confident and competent practitioners makes all the effort truly worthwhile.

References

1. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: http://www.ashp.org. Available from Internet. Accessed 2013 March 1.

2. Ibid.

3. Ibid.

4. Ibid.

5. Miller, DE, Woller,TW. Understanding reimbursement for pharmacy residents. Am J Health-Syst Pharm. 1998; 55:1620-3.