Education and Training

Pharmacy Expertise in Sterile Compounding (1911)
Source: Council on Education and Workforce Development
To support colleges of pharmacy in providing sterile compounding and aseptic technique instruction in didactic and experiential curricula that reflect the needs of the workforce; further,

To promote the use of sterile compounding training programs to foster an increase in the number of pharmacists and pharmacy technicians with sterile compounding expertise; further,

To advocate that pharmacists and pharmacy technicians who work in sterile compounding attain compounded sterile preparations advanced certifications.
This policy supersedes ASHP policy 0915.

Pharmacy Technician Training and Certification (1912)
Source: Council on Education and Workforce Development
To advocate for adoption of a national standard for accreditation of pharmacy technician education and training programs; further,

To advocate that a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required for all new pharmacy technicians by the year 2022; further,

To advocate that all pharmacy technicians be required to obtain and maintain Pharmacy Technician Certification Board certification; further,

To foster expansion of ASHP/ACPE-accredited pharmacy technician education and training programs.
This policy supersedes ASHP policy 1609.

Pharmacy Technician Student Drug Testing (1917)
Source: Pharmacy Technician Forum
To advocate for the use of pre-enrollment, random, and for-cause drug testing as a mandatory component throughout any accredited or unaccredited pharmacy technician training program and practice experience, based on defined criteria with appropriate testing validation procedures; further,

To encourage pharmacy technician training programs to develop policies and processes to identify impaired individuals; further,

To encourage pharmacy technician training programs to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage pharmacy technician training programs to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

Minimum Educational Qualification Standards for Pharmacists (1918)
Source: House of Delegates Resolution
To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or

Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

Clinician Well-being and Resilience (1825)
Source: Council on Education and Workforce Development
To affirm that burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To encourage the development of programs aimed at prevention, recognition, and treatment of burnout, and to support participation in these programs; further,

To encourage education and research on stress, burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective preventive and treatment strategies at an individual, organizational, and system level.

Student Pharmacist Drug Testing (1826)
Source: Council on Education and Workforce Development
To advocate for the use of pre-enrollment, random, and for-cause drug testing throughout pharmacy education and pharmacy practice experiences, based on defined criteria with appropriate testing validation procedures; further,

To encourage colleges of pharmacy to develop policies and processes to identify impaired individuals; further,

To encourage colleges of pharmacy to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage colleges of pharmacy to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

Collaboration on Experiential Education (1827)
Source: Council on Education and Workforce Development
To encourage practitioner contributions to pharmacy education; further,

To encourage pharmacists and pharmacy leaders to recognize their professional responsibility to contribute to the development of new pharmacy practitioners; further,

To promote collaboration of experiential teaching sites with the colleges of pharmacy (nationally or regionally), for the purpose of fostering preceptor development, standardization of experiential rotation schedule dates and evaluation tools, and other related matters; further,

To encourage colleges of pharmacy and health systems to define and develop collaborative organizational relationships that support patient care and advance the missions of both institutions in a mutually beneficial manner.
This policy supersedes ASHP policies 0315 and 0804.

1911

PHARMACY EXPERTISE IN STERILE COMPOUNDING

Source: Council on Education and Workforce Development

To support colleges of pharmacy in providing sterile compounding and aseptic technique instruction in didactic and experiential curricula that reflect the needs of the workforce; further,

To promote the use of sterile compounding training programs to foster an increase in the number of pharmacists and pharmacy technicians with sterile compounding expertise; further,

To advocate that pharmacists and pharmacy technicians who work in sterile compounding attain compounded sterile preparations advanced certifications.

This policy supersedes ASHP policy 0915.

Rationale

ASHP distinguishes between two needs related to pharmacy expertise in sterile compounding: a need for new pharmacy graduates to possess baseline training and knowledge of sterile compounding, and the need for pharmacists with an advanced body of knowledge on sterile compounding, especially in pharmacy departments where complex compounded sterile preparations (CSPs) are compounded.

Although there is a clear need for students to have a basic understanding of sterile compounding upon graduation, education in colleges of pharmacy on sterile compounding varies. Sterile compounding and aseptic technique instruction are important areas of pharmacy practice to incorporate in the didactic curriculum and during experiential education.

The complexity of intravenous therapy, the risk of errors or patient harm, and new biologic therapies all demand a higher level of expertise in sterile compounding in the pharmacy, however. United States Pharmacopeia Chapter 797 and other efforts have increased the focus on the quality of CSP compounding and have prompted organizations to improve staff training, facilities, and procedures. In such an environment, there is a clear need for pharmacists whose education, training, and experience in sterile compounding provide expertise rather than baseline knowledge. To demonstrate competency, pharmacy technicians should attain PTCB's advanced Compounded Sterile Preparation Technician (CSPT) certification, and pharmacists, the Board of Pharmacy Specialties (BPS) Compounded Sterile Preparations Pharmacy (BCSCP) certification.

1912

PHARMACY TECHNICIAN TRAINING AND CERTIFICATION

Source: Council on Education and Workforce Development

To advocate for adoption of a national standard for accreditation of pharmacy technician education and training programs; further,

To advocate that a pharmacy technician education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) be required for all new pharmacy technicians by the year 2022; further,

To advocate that all pharmacy technicians be required to obtain and maintain Pharmacy Technician Certification Board certification; further,

To foster expansion of ASHP/ACPE-accredited pharmacy technician education and training programs.

This policy supersedes ASHP policy 1609.

Rationale

In January 2017, the Pharmacy Technician Certification Board (PTCB) suspended the condition that by 2020 the completion of an accredited technician education and training program would be required to be eligible for the PTCB certification exam. There is no indication that PTCB will reinstate that requirement; however, ASHP supports completion of an education and training program accredited by ASHP and the Accreditation Council for Pharmacy Education (ACPE) as well as PTCB certification for all pharmacy technicians. Although education requirements have been added by PTCB to take the certification exam starting in 2020, completion of an accredited education and training program is only one pathway for eligibility for the exam; PTCB also recognizes equivalent work experience. If an applicant has completed an unaccredited program, there is a required attestation for the content of that program.

In 2018, ASHP and ACPE developed revised national standards that serve as a guide for the development of ASHP/ACPE-accredited pharmacy technician education and training programs. These standards serve as the criteria for the evaluation of new and established pharmacy technician training programs and will help ensure that pharmacy technicians possess the knowledge, skills, and abilities necessary for their critical role on the healthcare team. A number of environmental factors, including changes in state laws allowing for expanded roles, responsibilities, and authority for pharmacy technicians, prompted the reassessment of the standards, which were last revised in 2015. ASHP supports more uniform state statutes and regulations regarding pharmacy technicians. The anticipated increase in demand for enrollment in ASHP/ACPE-accredited training programs will require an expansion of the number and distribution of such programs, including innovative education and training formats.

The target date of 2022 was included to provide a goal for requiring that all new pharmacy technicians in hospitals and health systems complete a pharmacy technician education and training program accredited by ASHP and ACPE. The date is in line with the initiatives and timeline of the Stakeholder Advisory Committee (the Committee). This Committee continues to advance the recommendations of the Pharmacy Technician Stakeholder Consensus Conference ([Toward uniform standards for pharmacy technicians: Summary of the 2017 Pharmacy Technician Stakeholder Consensus Conference](#)), the national

consensus conference that engaged all sectors of pharmacy to define basic knowledge, skills, and abilities of pharmacy technicians, to promote and define advanced competencies, and to promote national definitions and regulation of pharmacy technicians. The Committee uses the recommendations and consensus statements to guide their work. Two of these statements are as follows:

> 2.1 The profession of pharmacy should move urgently towards the development and adoption of national standards for pharmacy technician education.

> 2.2 The profession of pharmacy should set a target for implementation of the national standard for pharmacy technician education at 3 to 5 years after adoption of the standard.

The accreditation standard for the education and training of pharmacy technicians was revised and approved by both the ASHP and ACPE Boards in June of 2018. Consistent with recommendation 2.2, 2022 is a reasonable target to require accredited training for new pharmacy technicians as it is four years from the time new standard was developed. The new standard was developed based on a job analysis of more than 44,000 pharmacy technicians in the U.S. The group developing the standard included educators; representatives from community, hospital, and chain pharmacy practice; and members of the Pharmacy Technician Accreditation Commission. More than 500 public comments were received and evaluated for inclusion in the revised standard before it was sent to the Boards of ASHP and ACPE for approval. The revised standard is divided into entry level and advanced, as recommended at the Pharmacy Technician Stakeholder Consensus Conference. This differentiation allows practice settings to have different education and training requirements based on the needs of the position. Additionally, boards of pharmacy can develop requirements based on entry-level competencies as a minimum standard and the advanced level can be an added credential that can be pursued based on employer requirements.

> The Committee is currently working with the National Association of Boards of Pharmacy (NABP) to modify the *Model State Pharmacy Act and Model Rules of the National Association of Boards of Pharmacy*. At the NABP national meeting in May 2019, a resolution was passed to convene a task force of stakeholders to evaluate and make recommendations to NABP regarding the education requirements, practice responsibilities, and competence assessments for pharmacy technicians.

> Additionally, work is being done at the state level with individual boards of pharmacy to evaluate requirements for accredited education and training for new pharmacy technicians. This activity follows consensus statement 5.2: The level of urgency for achieving state-to-state consistency in regulation of pharmacy technicians' scope of practice, education, certification, and licensure or regulation is high.

> At the state level, advocacy will include several specific issues for boards of pharmacy to include as they consider regulations for technicians:

- There should be clear distinctions between pharmacy technicians and student pharmacists. Technician requirements should not be applied to student pharmacists.
- There should be a provision for a "technician in training" that would allow a technician who is enrolled in an accredited education and training program to be eligible to work in a pharmacy as long they complete the program in some prescribed amount of time (e.g., 12-18 months).

1917

PHARMACY TECHNICIAN STUDENT DRUG TESTING

Source: Pharmacy Technician Forum

To advocate for the use of pre-enrollment, random, and for-cause drug testing as a mandatory component throughout any accredited or unaccredited pharmacy technician training program and practice experience, based on defined criteria with appropriate testing validation procedures; further,

To encourage pharmacy technician training programs to develop policies and processes to identify impaired individuals; further,

To encourage pharmacy technician training programs to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage pharmacy technician training programs to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

Rationale

Pharmacy technicians are essential members of the healthcare team and help ensure the health, safety, and welfare of patients. They have access to controlled substances and confidential information, and operate in settings that require the exercise of good judgment and ethical behavior. In addition, some state boards of pharmacy have reported that drug-abusing and -diverting persons are enrolling in pharmacy technician training programs to access drugs during experiential training and employment. Thus, an assessment of a pharmacy technician student's possible impairment, which could diminish his or her capacity to function in such a setting, is imperative to promote the highest level of integrity in healthcare services. ASHP recognizes that drug testing pharmacy technician students, whose responsibilities may bring them into contact with controlled substances, is an essential element of diversion prevention programs. Pre-enrollment, random, and for-cause drug testing should be performed based on defined criteria, with appropriate testing validation procedures, and have demonstrated effectiveness detecting commonly abused or illegally used substances.

1918

MINIMUM EDUCATIONAL QUALIFICATION STANDARDS FOR PHARMACISTS

Source: House of Delegates Resolution

To support minimum educational qualification standards for pharmacists to practice pharmacy that are consistent with the licensing standards of state boards of pharmacy; further,

To oppose the basic education requirement within the Office of Personnel Management Classification & Qualifications - General Schedule Qualification Standards - Pharmacy Series, 0660, requiring a Doctor of Pharmacy or Doctor of Philosophy degree as the minimum qualification to practice pharmacy.

Rationale

In September 2017, the U.S. Office of Personnel Management (OPM) issued a new qualification standard for pharmacists, GS-0660. The new standard lists the basic educational requirement for pharmacists as a Doctor of Pharmacy (Pharm.D.) or Doctor of Philosophy (Ph.D.) degree. To set this requirement, OPM must have determined that pharmacy cannot be performed by persons without one of these degrees, because Title 5 U.S.C. 3308 permits the establishment of minimum educational requirements only when OPM has determined that the work cannot be performed by persons who do not possess the prescribed minimum education.

All 50 states currently allow pharmacists with a bachelor's degree in pharmacy (B.S.Pharm.) to obtain licensure and practice pharmacy, which indicates that all state legislatures or regulators have concluded that pharmacists with a B.S.Pharm. degree can practice pharmacy safely and effectively. In the U.S., the B.S.Pharm. degree was awarded until 2005; in 2006, the Pharm.D. degree became the only entry-level degree awarded. A 2014 survey of the pharmacy workforce found that only 40% of pharmacists had earned a Pharm.D. The minimum educational requirements set by OPM would automatically disqualify 60% of pharmacists from entering the federal government workforce, an inequitable practice not seen outside the federal sector. The OPM minimum educational requirement also creates a monumental challenge to building and maintaining the pharmacist workforce the Department of Defense needs to support U.S. warfighting efforts and take care of veterans. ASHP recognizes that pharmacists must possess the education, training, and experience required to effectively, efficiently, and responsibly fulfill their roles. Further, ASHP supports licensure by a state board of pharmacy as the minimum requirement for pharmacy practice in its Minimum Standard for Pharmacies in Hospitals.

1825
Clinician Well-being and Resilience
Source: Council on Education and Workforce Development

To affirm that burnout adversely affects an individual's well-being and healthcare outcomes; further,

To acknowledge that the healthcare workforce encounters unique stressors throughout their education, training, and careers that contribute to burnout; further,

To declare that healthcare workforce well-being and resilience requires shared responsibility among healthcare team members and between individuals and organizations; further,

To encourage individuals to embrace well-being and resilience as a personal responsibility that should be supported by organizational culture; further,

To encourage the development of programs aimed at prevention, recognition, and treatment of burnout, and to support participation in these programs; further,

To encourage education and research on stress, burnout, and well-being; further,

To collaborate with other professions and stakeholders to identify effective preventive and treatment strategies at an individual, organizational, and system level.

Rationale

Burnout is a syndrome characterized by a high degree of emotional exhaustion, high depersonalization (e.g., cynicism), and a low sense of personal accomplishment from work due to both internal and external factors. More than half of U.S. physicians show symptoms of burnout, which is nearly twice as high as other U.S. workers, even after controlling for work hours and other factors. Between 2011 and 2014, the prevalence of burnout increased by 9% among physicians while remaining stable in other U.S. workers. The American Foundation for Suicide Prevention reports that 300-400 physicians commit suicide each year, approximately one per day, double that of the general population. Nurses show a similarly high prevalence of burnout and depression. A 2007 study reported that 22-35% of nurses had a high degree of emotional exhaustion. A survey at Duke University Hospital found that 20% of pharmacists were at risk for burnout. And although less is known about other members of the healthcare team, data suggest a similar prevalence of burnout among pharmacy technicians, nurse practitioners, and physician assistants.

Stress in our clinical learning environment can affect all healthcare learners, with negative outcomes ranging from poor well-being to substance abuse to depression, even suicide. In May 2018, a New York City medical student and resident committed suicide within a week of each other. One review estimates that nearly 29% of medical residents suffer from depression or depressive symptoms, well above the 16% estimated prevalence in the general population. One study has shown that pharmacy residents exhibit high levels of perceived stress, especially those who work more than 60 hours per week, and perceived stress is highly correlated to negative effects.

ASHP joined the National Academy of Medicine (NAM) Action Collaborative on Clinician Well-Being and Resilience in 2017. The goals of the Collaborative are to (1) assess and understand the underlying causes of clinician burnout and suicide, and (2) advance evidence-based solutions that reverse the trends in clinician stress, burnout, and suicide. Clinician burnout is a concern because, in addition to clinician suffering, clinician burnout has been associated with increased rates of medical errors, healthcare-associated infection, and patient mortality. Clinician burnout also decreases patient satisfaction and healthcare workforce productivity. Students in the health professions are also susceptible to burnout.

The NAM Action Collaborative Conceptual Model depicts both individual and external factors affecting well-being and resilience and indicates that it requires a combined effort from the individual and the system to address and prevent burnout. Studies suggest that burnout is a problem of the entire healthcare organization as well as individual clinicians, so maintaining clinician well-being and resilience requires a combined effort by the individuals and their employers. Pharmacists, along with other healthcare professionals and administrators, have a role in researching and solving the problem. To be successful, interventional programs must promote prevention, recognition, and treatment of burnout, and healthcare organizations must foster a culture that supports not just participation in these programs but a sense of personal responsibility for developing and maintaining resilience. Providing patient care is meaningful

and purposeful work. A healthcare organization with a resilient workforce will provide the best healthcare outcomes.

1826
Student Pharmacist Drug Testing
Source: Council on Education and Workforce Development

To advocate for the use of pre-enrollment, random, and for-cause drug testing throughout pharmacy education and pharmacy practice experiences, based on defined criteria with appropriate testing validation procedures; further,

To encourage colleges of pharmacy to develop policies and processes to identify impaired individuals; further,

To encourage colleges of pharmacy to facilitate access to and promote programs for treatment and to support recovery; further,

To encourage colleges of pharmacy to use validated testing panels that have demonstrated effectiveness detecting commonly misused, abused, or illegally used substances.

Rationale
Persons 18-25 years of age have the highest prevalence of prescription drug misuse among all age groups. Moreover, there is growing evidence that prescription drug misuse has been increasing among U.S. college students, and it is second to marijuana as the most common form of substance abuse. Pharmacy professionals and students are entrusted with the health, safety, and welfare of patients. They have access to controlled substances and confidential information, and operate in settings that require the exercise of good judgment and ethical behavior. Thus, an assessment of a student pharmacist's possible impairment, which could diminish his or her capacity to function in such a setting, is imperative to promote the highest level of integrity in healthcare services. ASHP recognizes that drug testing student pharmacists, whose responsibilities may bring them into contact with controlled substances, is an essential element of diversion prevention programs. Pre-enrollment, random, and for-cause drug testing should be performed based on defined criteria, with appropriate testing validation procedures, and have demonstrated effectiveness detecting commonly abused or illegally used substances. In addition, drug testing should be supported by an addiction recovery program, as outlined in the [ASHP Statement on the Pharmacist's Role in Substance Abuse Prevention, Education, and Assistance](#).

1827
Collaboration on Experiential Education
Source: Council on Education and Workforce Development

To encourage practitioner contributions to pharmacy education; further,

To encourage pharmacists and pharmacy leaders to recognize their professional responsibility to contribute to the development of new pharmacy practitioners; further,

To promote collaboration of experiential teaching sites with the colleges of pharmacy (nationally or regionally), for the purpose of fostering preceptor development, standardization of experiential rotation schedule dates and evaluation tools, and other related matters; further,

To encourage colleges of pharmacy and health systems to define and develop collaborative organizational relationships that support patient care and advance the missions of both institutions in a mutually beneficial manner.

This policy supersedes ASHP policies 0315 and 0804.

Rationale
As stated in the [ASHP Statement on Professionalism,](#) one of the fundamental services of a professional is recruiting, nurturing, and securing new practitioners to that profession's ideals and mission. Because the principles of institutional pharmacy practice are not emphasized in typical pharmacy curricula, professional socialization is especially important for pharmacists who practice in those settings. The experiential education experience of student pharmacists is a partnership between colleges of pharmacy and the experiential teaching sites. Collaboration between the colleges of pharmacy and experiential training sites on preceptor development, standardized rotation schedule dates, evaluation tools, and other materials helps to assure the best possible experience for student pharmacists, preceptors, and the experiential education site. In addition, collaboration allows both entities to fulfill their missions by participating in mutually beneficial activities, improving patient outcomes, and helping students and their institutions achieve educational and research objectives.

1829
Pharmacy Training Models
Source: Council on Education and Workforce Development
To promote pharmacy training models that: (1) provide experiential and residency training in interprofessional patient care; (2) use the knowledge, skills, and abilities of student pharmacists and residents in providing direct patient care; and (3) promote use of innovative and contemporary learning models; further,

To support the assessment of the impact of these pharmacy training models on the quality of learner experiences and patient care outcomes.

This policy supersedes ASHP policy 1316.

Rationale
Pharmacy training models are continually evolving. The ideal training model includes characteristics such as flexibility to be useful in all patient care settings, providing patient care through an interprofessional team, and allowing team members to practice at the top of their licenses. Many healthcare organizations are successfully employing innovative and contemporary training models. One such model is the the layered learning approach to

residency and student pharmacist training, in which a pharmacist oversees multiple residents, students, and sometimes generalist pharmacists. Each member of this pharmacy team is integrated into a patient care team, with specific roles and responsibilities, but each also has accountability to the supervising pharmacist. The layered learning model may be more practical in larger institutions, however, because they have more staff, residents, and students than smaller hospitals. ASHP recognizes that it is important to individualize the training program to the practice site and its corresponding practice model, and supports the assessment of the impact of these pharmacy training models on the quality of learner experiences and patient care outcomes.

1706
ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process
Source: Council on Education and Workforce Development
    To encourage all educators of the pharmacy workforce to use ASHP statements, guidelines, and professional policies as an integral part of education and training.

    This policy supersedes ASHP policy 0705.

Rationale
ASHP members create professional policy that reflect best practices and influence the future direction of the profession and patient care. ASHP's professional policies contain varying levels of detail, but all contain guiding principles for the profession. The use of professional policy should be incorporated into all forms of professional education, including pharmacy and technician students, residents, and practitioners and widely used across the pharmacy profession.

1611
Developing Leadership Competencies
Source: Council on Education and Workforce Development
To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for pharmacy practitioners to move into leadership roles; further,

    To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,

    To encourage pharmacy practitioners to obtain the skills necessary to pursue administrative, managerial, and leadership roles; further,

    To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,

To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,

To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.

This policy supersedes ASHP policy 1518.

Rationale
In their 2013 report, White and Enright anticipated a high rate in turnover of pharmacy directors and middle managers over the coming decade. Healthcare organizations must address this ongoing challenge if there are to be a sufficient number of new directors and managers to fill those positions. Factors that may contribute to a shortage of potential new leaders and managers include:

- New graduates frequently accept clinical positions or positions in drug distribution. After a few years, they may have a desire to assume managerial positions in health-system pharmacies, but training programs may not be convenient for them, and they may not have the resources to obtain training.
- Health-system pharmacy management positions do not turnover often. Prospective managers view those positions as unavailable for the near future, so there is little incentive to obtain training to be ready to move into those positions.
- Job satisfaction among pharmacy managers appears low to prospective managers.
- Frequent turnover in organizational administrative positions (above pharmacy) is frustrating to pharmacy directors, because they continually need to inform new administrators about the organization's medication-use strengths and weaknesses and the pharmacy department's roles, strategic plans, and priorities for sustaining quality and making improvements. In those turnover circumstances, diligently achieved pharmacy service improvements can sometimes be eroded and reversed. The ensuing frustration can induce pharmacy directors to depart voluntarily from management positions and make those positions unattractive to others.
- Flattening of organizational structures in healthcare organizations has eliminated numerous managerial positions in pharmacies, leaving fewer pharmacists to serve as mentors for prospective managers. Without positive role models, it is difficult for pharmacists to gain good management experience.
- Pharmacy management positions that combine clinical and management responsibilities sometimes allow little time for clinical work.
- Many pharmacists, even those in managerial positions, have no training in personnel administration. Skills such as conflict resolution and negotiation are rarely taught in pharmacy curricula but are very important in leadership positions.
- In some healthcare organizations, managers receive raises predicated on overall organizational or departmental performance. However, the compensation of some staff may be based on individual performance. These differing bases can lead to instances in which the compensation of those supervised is higher than that of their managers.

When that occurs, it can be a disincentive to individuals considering management positions.

Leadership and managerial potential in today's student pharmacists and new graduates is as high as it has ever been, but more effort is needed to nurture that potential and develop leadership and management skills in practice. Colleges of pharmacy, state associations, residency programs, and practitioners themselves need to foster the development of leadership and management skills. ASHP can help foster leadership competencies at all levels of practice through actions such as providing education about leadership and management roles, developing Web-based resources, and facilitating networking among leaders, managers, and those aspiring to such roles.

Leadership continues to be a critical area for development, as leadership is a necessary competency in the provision of patient care. There are multiple avenues available to pharmacists for leadership development and ASHP should take the lead in fostering this effort.

1612
Interprofessional Education and Training
Source: Council on Education and Workforce Development
To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education, mentorship, and professional development for student pharmacists, residents, and pharmacists; further,

To encourage and support pharmacists' collaboration with other health professionals and healthcare executives in the development of interprofessional, team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of healthcare professionals.

This policy supersedes ASHP policy 1014.

Rationale
Pharmacist involvement in team-based patient care improves medication-use safety and quality and reduces healthcare costs. For patient-care teams to be effective, they must possess unique skills that facilitate effective team-based interactions. Some pharmacists are exposed to team-based care models through interprofessional education and interaction with students of other disciplines when they are student pharmacists. Some colleges of pharmacy have very effective interprofessional didactic courses that include medical, pharmacy, nursing, and other health professional students. Additionally, most experiential rotations involve interaction with other members of the healthcare team and help students of all disciplines learn about the expertise of other team members. However, not all colleges and schools are effective in providing

interprofessional education that facilitates team-based patient care. The reasons vary, but may include differences in teaching philosophies or a lack of access to other health professional schools at the university or campus.

The Hospital Care Collaborative (HCC) has described common principles for team-based care. The HCC principles recognize the knowledge, talent, and professionalism of all team members and support role delineation, collaboration, communication, and the accountability of individual team members and the entire team. The HCC principles note that collaboration of the healthcare team can lead to improved systems and processes that provide care more efficiently and result in better patient outcomes. The HCC states that current undergraduate and postgraduate professional education of team members is inadequate to promote true team functions.

ASHP believes that interprofessional education is important not only for student pharmacists but also throughout one's professional career. Similarly, it is important for other professionals on the team so that collaboration and synergistic relationships can develop. Failure to establish these collaborative working relationships early in one's career can result in poor interactions in years to come. A positive working relationship, including interprofessional mentorship, with physicians and nurses is productive, while a bad working relationship can be counterproductive and devastating to all parties, including patients.

1613
Cultural Competency
Source: Council on Education and Workforce Development

To foster the ongoing development of cultural competency within the pharmacy workforce; further,

To educate healthcare providers on the importance of providing culturally congruent care to achieve quality care and patient engagement.

This policy supersedes ASHP policy 1414.

Rationale
The United States is rapidly becoming a more diverse nation. Culture influences a patient's belief and behavior toward health and illness. Cultural competence can significantly affect clinical outcomes. Research has shown that overlooking cultural beliefs may lead to negative health consequences.[1] According to the National Center for Cultural Competency, there are numerous examples of benefits derived from the impact of cultural competence on quality and effectiveness of care in relation to health outcomes and well-being.[2] Further, pharmacists can

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1Administration on Aging. Achieving cultural competence. A guidebook for providers of services to older Americans and their families. Available at: http://archive.org/details/achievingcultura00admi (accessed October 17, 2013)

2Goode TD, Dunne MC, Bronheim SM. The evidence base for cultural and linguistic competency in health care. The Commonwealth Fund; 2006. Available http://www.commonwealthfund.org/usr_doc/Goode_evidencebasecultlinguisticcomp_962.pdf (accessed October 17, 2013)

contribute to providing "culturally congruent care," which can be described as "a process of effective interaction between the provider and client levels" of healthcare that encourages provider cultural competence while recognizing that "[p]atients and families bring their own values, perceptions, and expectations to healthcare encounters which also influence the creation or destruction of cultural congruence."[3] The Report of the ASHP Ad Hoc Committee on Ethnic Diversity and Cultural Competence[4] and the ASHP Statement on Racial and Ethnic Disparities in Health Care[5] support ways to raise awareness of the importance of cultural competence in the provision of patient care so that optimal therapeutic outcomes are achieved in diverse populations.

1317
EDUCATION AND TRAINING IN HEALTH CARE INFORMATICS PHARMACY
Source: Council on Education and Workforce Development

      To recognize the significant and vast impacts of health-system information systems, automation, and technology changes on safe and effective use of medications; further,

      To foster, promote, and lead the development of and participation in formal health care informatics educational programs for pharmacists, pharmacy technicians, and student pharmacists.

Rationale
With growing use of automation and technology, there is a growing need for informatics-trained pharmacists and pharmacy technicians, yet there are few training programs or residencies. This shortage of trained individuals has led to on-the-job training and potentially less-than-optimal implementation of new information systems and technology. New educational programs, or adaptation of existing ones, would help ease this lack of trained individuals and lead to better technology outcomes. To most effectively accomplish this goal, ASHP must lead the development of such programs and encourage participation by pharmacists, pharmacy students, and pharmacy technicians.

1201
PRECEPTOR SKILLS AND ABILITIES
Source: Council on Education and Workforce Development

      To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,
      To provide tools, education, and other resources to develop preceptor skills.

Rationale

3Schim SM, Doorenbos AZ. A Three-dimensional Model of Cultural Congruence: Framework for Intervention. *J Soc Work End Life Palliat Care*. 2010; 6:256–70.

4Report of the ASHP Ad hoc committee on ethnic diversity and cultural competence. *Am J Health-Syst Pharm.* 2005; 1924-30.

5 ASHP Statement on Racial and Ethnic Disparities in Health Care. Am J Health-Syst Pharm. 2008; 65:728–33.

The quality of pharmacy education is directly tied to the quality and effectiveness of its preceptors. Growth in the number and size of colleges of pharmacy has increased demand for teaching sites and for qualified preceptors to provide experiential training and residency rotations at those sites. As a result, teaching sites are often selected with little proof of the quality of the site or the ability of its preceptors, and many of those preceptors lack experience or training in teaching and precepting students and residents. Although nearly all colleges of pharmacy try to provide preceptor training, their efforts to develop preceptors are often inconsistent and ineffective due to resource constraints. In addition to improved training of preceptors, the profession needs a mechanism for evaluating the skills of preceptors and teachers.

There has been little coordination of preceptor development at the national level. The quality and effectiveness of preceptors is important to the entire profession and deserves a national platform and dedicated resources.

1203
QUALIFICATIONS OF PHARMACY TECHNICIANS IN ADVANCED ROLES
Source: Council on Education and Workforce Development

To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.

Rationale
A growing number of hospitals utilize pharmacy technicians in advanced or specialized roles beyond those traditionally filled by technicians: medication preparation, distribution, and purchasing. These advanced or specialized roles include performing medication reconciliation, collecting laboratory data, and managing automation and technology, among others. While there has been a good deal of discussion about minimum standards for education and training of pharmacy technicians in general, there has been little discussion about technicians in these specialized roles. These advanced roles will require different skills and competencies, and pharmacy technicians will require additional, task-specific training and should demonstrate competency before being allowed to perform such tasks. Hospitals and health systems will

need to consider the potential risk to patients of expanding the roles of pharmacy technicians and establish quality assurance metrics to assure patient safety.

1108
QUALITY OF PHARMACY EDUCATION AND EXPANSION OF COLLEGES OF PHARMACY
Source: Council on Education and Workforce Development

To support the Accreditation Council for Pharmacy Education's continuing role of promulgating accreditation standards and guidelines and engaging in sound accreditation processes to ensure quality in the education provided by colleges of pharmacy; further,

To acknowledge that, in addition to a robust curriculum, access to quality experiential educational sites and the availability of qualified faculty (including preceptors and specialty-trained clinical faculty) are essential determinants of the ability to expand enrollment in existing or additional colleges of pharmacy; further,

To oppose expansion of enrollment in existing or new colleges of pharmacy unless well-designed projections demonstrate that such enrollment increases are necessary to maintain a viable pharmacist workforce.

This policy supersedes ASHP policy 0607.

Rationale
The growth in the number and capacity of colleges of pharmacy in recent years has been remarkable. Ten years ago, when there was a severe pharmacist shortage, new colleges were welcomed to help meet the anticipated needs of the pharmacy workforce. The pharmacist shortage has now abated, but new colleges continue to be established and capacity of existing colleges expanded. This growth, along with other factors, has led to considerable difficulty for colleges of pharmacy in locating experienced faculty. There are also growing concerns about the limited number of quality experiential education sites and how future demands for training will be met. These two factors alone have raised worries about the quality of education and the readiness of new pharmacy graduates. High quality can be ensured through the existing mechanism of Accreditation Council for Pharmacy Education (ACPE) accreditation, regardless of the number of colleges and the number of students. However, this assumes rigid enforcement

of ACPE's accreditation standards and guidelines, the availability of qualified faculty and preceptors, and an adequate capacity in practice to provide the necessary experiential education.

The Council discussed the mismatch between pharmacy workforce supply and demand. Demand far exceeded supply in 2000, but growth in colleges and other factors now have supply exceeding demand. The Council discussed how there could be better planning to avoid these situations, both of which are costly to the health care system and present risks to quality and patient care. It was suggested that well-designed workforce projections might be useful in determining the need for new or expanded educational capacity.

1109
RESIDENCY EQUIVALENCY
Source: Council on Education and Workforce Development
   To acknowledge the distinct role of ASHP-accredited residency training in preparing pharmacists to be direct patient-care providers; further,

   To recognize the importance of clinical experience in developing practitioner expertise; further,

   To affirm that there are no objective means to convert or express clinical experience as equivalent to or a substitute for the successful completion of an ASHP-accredited residency.

Rationale
ASHP's position on the need for residency-trained pharmacists is well established and described in the *ASHP Long-Range Vision for the Pharmacy Workforce in Hospitals and Health Systems*. It has been suggested that a way to achieve the goal of having all pharmacists in direct patient-care roles be residency trained would be to establish a process for reviewing a "portfolio" against pre-established criteria to grant a "residency equivalency." The Council, Board, and House concluded that both residency training and experience are important and valuable, but different, and that it would not be appropriate to create a process that attempts to convert one into the other. The intent of the goal of having all new college of pharmacy graduates who provide direct patient care residency trained by 2020 is to enhance the skills of those practitioners, and the creation of a residency equivalency process might dilute the value of that residency training and undermine achievement of the goal.
   The Council, Board, and House also discussed the process used by ASHP to waive the requirement for a postgraduate year one (PGY1) residency for experienced practitioners who wish to enter a postgraduate year two (PGY2) residency directly. While this process does consider total experience in granting the waiver, and may seem to contradict the recommended policy, the applicant still completes a residency, ultimately gaining those experiences unique to residency training.

1110
PHARMACY INTERNSHIPS
Source: Council on Education and Workforce Development
   To encourage the National Association of Boards of Pharmacy to develop standardized pharmacy internship hour requirements that would be used uniformly by all state boards of pharmacy; further,

   To support structured requirements, goals, and objectives for pharmacy internship experiences, in alignment with requirements for introductory and advanced pharmacy practice experiences; further,
   To promote and expand new staffing models that foster expanded roles for pharmacy interns, providing work experiences that build upon their knowledge and help them develop as future pharmacists.

Rationale

The pharmacy internship requirement established by state boards of pharmacy has changed little in many states, even with the change to a six-year doctor of pharmacy curriculum. Many states allow some or all internship hour requirements to be completed as part of a student's introductory pharmacy practice experience (IPPE) or advanced pharmacy practice experience (APPE) rotations; others require students to complete internship hours separately.

Inconsistencies in internship requirements between states have had significant implications for pharmacy residents. Pharmacy graduates from a state with minimal internship requirements might match with a residency program in a state with stringent internship requirements, sometimes delaying their eligibility for licensure until they can complete internship requirements in their residency state. Greater standardization would prevent these issues as residents move to other states to start their programs.

Since most states do not specify the roles and duties of pharmacy interns, many work as pharmacy technicians, which may result in a good learning experience but in some cases leaves a negative impression on the student. The lack of standardized goals and objectives for internships has resulted in experiences that are highly variable. Some hospitals have chosen to enhance their internship experience by adding structure and specific goals to be achieved. While these programs are few in number, they are viewed as highly valued learning experiences for those who participate.

The requirements for IPPEs and APPEs should be considered as internship requirements are established. Each experience has a distinct role in the development and education of pharmacy students, and care should be taken to make sure that each experience is maximized and that core elements are not left out.

This policy supersedes ASHP policy 0802.

1111

STATE-SPECIFIC REQUIREMENTS FOR PHARMACIST CONTINUING EDUCATION
Source: Council on Education and Workforce Development

To support the standardization of state pharmacist continuing education requirements; further,

To advocate that state boards of pharmacy adopt continuing professional development (CPD) as the preferred model for maintaining pharmacist competence and structure continuing education requirements as a component of CPD.

Rationale

All 50 states require continuing education for pharmacists as a means of maintaining their competence. State requirements for continuing education differ, in numbers of hours and the time frame within which they must be collected and reported, for example. Some state boards of pharmacy have established specific educational requirements for individual topic areas they concluded should be mandatory. These initially included topics such as state-specific pharmacy law and human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS),

but more recently states have included requirements for education on medication safety, pain and palliative care, and patient management. Some states also specify the number of hours that must be obtained by "live" presentation rather than home study courses. As more states develop unique requirements, many pharmacists who are licensed in multiple states are finding it difficult to meet the unique requirements of each individual state.

In addition to continuing education required by state boards, many new Risk Evaluation and Mitigation Strategies (REMS) programs will require drug-specific education for pharmacists before they are permitted to handle or dispense the medications.

The Council also discussed the limited use of CPD by pharmacists and the few states that allow CPD as part of their continuing education requirements.

1112
INNOVATIVE RESIDENCY MODELS
Source: Council on Education and Workforce Development

To support the development of innovative residency models that meet ASHP accreditation requirements.

Rationale
A growing number of residency programs have developed residency positions that are "nontraditional," in that they do not occur in a contiguous 12-month period beginning in July and finishing the following June. Some of these innovative programs schedule the participant for one month as a resident, followed by two months as staff, with this cycle repeated over a three-year period. This allows some individuals, usually experienced individuals already on staff at the institution, to complete a residency while maintaining a more consistent work schedule and lifestyle. Some other settings have adopted a model geared toward new graduates, alternating months between residency rotation and staffing.

The concept of innovative, nontraditional residencies allows another way for established pharmacists to obtain a pharmacy residency when a conventional 12-month contiguous program is not possible. The Council, Board, and House expressed support for this model as long as ASHP accreditation standards and residency goals and objectives are utilized as they would be in a conventional program.

1008
EMPLOYMENT CLASSIFICATION AND DUTY HOURS OF PHARMACY RESIDENTS
Source: Council on Public Policy

To advocate that pharmacy residents should be classified as exempt employees; further,

To advocate that pharmacy residents be subject to duty hour limits (similar to resident physicians) with respect to all clinical and academic activities during their training program in accordance with the Accreditation Council on Graduate Medical Education (ACGME) standards and ASHP accreditation standards for pharmacy residency programs.

Rationale

In some states, pharmacy residents are classified as non-exempt employees (eligible for overtime pay) in accordance with guidance from state employment offices. ASHP believes that there is an important job classification distinction between pharmacists employed by a hospital or health system and pharmacy residents who are part of an organization's residency program. Specifically, pharmacy residents are in an organized, directed, and accredited postgraduate training program that builds upon knowledge, skills, attitudes, and abilities gained from an accredited professional pharmacy-degree program. Pharmacy residents receive a salary and are subject to the same duty hours as physicians. Classifying pharmacy residents as non-exempt employees is overly burdensome and counterproductive to the residency experience and the objectives of the training program. Moreover, such misclassification could inhibit the development of an important component of the pharmacy workforce at a time of increased demand for pharmacist services as health care reform is implemented.

0913
PHARMACY STUDENT EXPERIENCES IN MEDICALLY UNDERSERVED AREAS
Source: Council on Education and Workforce Development
　　To encourage colleges of pharmacy to require student learning experiences in traditionally medically underserved areas and with diverse patient populations.

Rationale
Numerous reports demonstrate how pharmacy students and practice sites benefit from experiential rotations in rural and urban settings, especially in settings or areas classified as medically underserved. Students learn about the cultural, financial, language, and other challenges encountered in these settings, and these skills are often invaluable when they enter practice. In addition, a student's exposure to a new practice area may result in more interest in such sites and provide career choices that might otherwise not have been considered.

　　ASHP does not support mandating rotations in these settings, since there are many ways to provide the interaction, and there are concerns about how colleges could develop an infrastructure for providing these experiences. The challenges of finding good teaching sites in these settings are formidable and include a limited number of sites, a lack of qualified preceptors, and geographic distances from the college that result in housing needs.

　　The Accreditation Council for Pharmacy Education currently requires colleges of pharmacy to ensure that graduates can provide patient-centered care that addresses cultural diversity. Although experiential rotations may be the most common way for students to be exposed to diverse patient populations, there are many other creative ways in which this goal is being accomplished. Some colleges, for example, require students to perform service learning projects with a focus on underserved populations.

0915
PHARMACY EXPERTISE IN THE PREPARATION AND HANDLING OF INJECTABLE MEDICATIONS
Source: Council on Education and Workforce Development

To encourage colleges of pharmacy to include sterile compounding and aseptic technique instruction in the didactic curriculum and during experiential education; further,

To support the development of postgraduate, curriculum-based sterile compounding training programs to foster an increase in the number of pharmacists with sterile compounding expertise.

Rationale
ASHP distinguishes between two needs related to pharmacy expertise in sterile product preparation: a need for new pharmacy graduates to possess baseline training and knowledge of sterile product preparation, and the need for pharmacists with an advanced body of knowledge on sterile product preparation, especially in pharmacy departments where complex sterile preparations are compounded.

Although there is a clear need for students to have a basic understanding of sterile compounding upon graduation, education in colleges of pharmacy on sterile compounding varies greatly. Some students learn to compound intravenous admixtures proficiently by spending time working in a hospital pharmacy, while others graduate without ever preparing an intravenous solution. Colleges of pharmacy should include sterile compounding and aseptic technique instruction in the didactic curriculum and during experiential education.

The complexity of intravenous therapy, the risk of errors or patient harm, and new biologic therapies all demand a higher level of expertise in sterile compounding in the pharmacy, however. USP Chapter 797 and other efforts have increased the focus on the quality of injectable medication preparation and have prompted organizations to improve staff training, facilities, and procedures. In such an environment, there is a clear need for pharmacists whose education, training, and experience in sterile compounding provide expertise rather than baseline knowledge. Many pharmacy departments, even in larger hospitals, have relatively few staff members who can fulfill this role. Often these individuals have developed their expertise over time, and their loss, through retirement or job changes, can have severe impacts, as training opportunities are limited. Postgraduate, curriculum-based sterile compounding training programs are therefore needed to increase in the number of pharmacists with sterile compounding expertise.

0916
CONTINUING PROFESSIONAL DEVELOPMENT
Source: Council on Education and Workforce Development
To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation; further,

To continue the development of a variety of mechanisms and tools that pharmacists can use to assess their CPD needs; further,
To encourage individual pharmacists to embrace CPD as a means of maintaining their own professional competence; further,

To encourage pharmacy managers to promote CPD as the model for ensuring the competence of their staff; further,

To collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods for implementing CPD; further,

To strongly support objective assessment of the impact of CPD on pharmacist competence; further,

To endorse the efforts of colleges of pharmacy and ASHP-accredited pharmacy residency programs to teach the principles, concepts, and skills of CPD.

Rationale

Maintaining competence throughout one's career is part of a professional's obligation. Traditionally, this has been done through continuing education (CE) activities, but CE has several shortcomings. There is often no mechanism to ensure that CE is effective, since most CE activities have no summative evaluation component. (Summative evaluation takes place at the completion of a program to determine whether goals and objectives have been met.) In addition, CE programs are not usually curricular, are not always competency-directed, and tend to be content-oriented rather than skill-based. There is little evidence that CE changes practice or has an impact on patient outcomes.

Continuing professional development (CPD) is a model that addresses many of the shortcomings of the CE model. CPD differs from CE in that it is ongoing and includes the entire scope of an individual's practice, it is often undertaken in partnership with the professional's employer, it is practitioner-centered and self-directed, and it is intended to be outcomes-oriented. Many pharmacy professionals already assume responsibility for their professional growth and development by reflecting on their practice, recognizing needs, and seeking educational opportunities and activities that will meet those needs. Even when these activities are not documented or reported, this process incorporates many of the principles of CPD.

CPD is a cyclical, five-step process that begins with a self-appraisal by the individual professional to determine educational needs and progresses through the development of a personal plan to meet those needs, an action phase in which the professional participates in the activities identified in the personal plan, a documentation component in which the professional keeps records of all CPD activities in which he or she participates, and an evaluation phase to determine whether the CPD needs were met, if practice has been improved, if patients have benefited, and if learning was or was not accomplished (and why). This step then feeds back into the self-appraisal stage and the cycle continues.

In the self-appraisal phase, identification of CPD needs may be accomplished through personal assessment, performance review by a manager or supervisor, an audit exercise undertaken with other professionals, or as a requirement of a professional organization or regulatory body. There are a variety of mechanisms that pharmacists can use to self-assess their CPD needs. Self-assessment is not a skill most professionals learn during their professional

education and training, however. For CPD to be effective, professionals must learn this skill before entering the CPD cycle, in colleges of pharmacy and residency programs.

In the next phase, the personal plan, the professional identifies resources and actions to meet the identified CPD needs. Activities may be informal, such as study clubs, observation of a colleague's practice, and conversations with colleagues, or they may be more formal, such as CE workshops, short courses, seminars, self-study programs, or graduate-level course work.

Whether formal or informal, managed CPD requires that the professional document participation in these activities. This documentation becomes the foundation of the professional's CPD portfolio. Documentation of participation in formal activities is usually given by the provider, but more informal and self-directed activities, such as observation of a colleague's practice, require the individual to establish a format for documentation in the portfolio.

In the final phase, which feeds back into self-appraisal, the professional self-evaluates, is evaluated by a manager or supervisor, enlists the aid of peers, or is evaluated by an external (e.g., regulatory) body. It is important in this phase to determine whether learning was or was not accomplished (and if not, why not) and to feed this back into the ongoing CPD cycle.

This policy supersedes ASHP policy 0408.

0917
PHARMACY RESIDENCY TRAINING
Source: Council on Education and Workforce Development
To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available.

This policy supersedes ASHP policy 9911.

Rationale
ASHP is committed to achieving the goal that by the year 2020 all new college of pharmacy graduates who will be providing direct patient care will be required to complete an ASHP-accredited postgraduate-year-one residency (see ASHP policy 0701). To accomplish this goal, ASHP will need to increase the number of ASHP-accredited pharmacy residency training programs and positions.

0701
REQUIREMENT FOR RESIDENCY
Source: House of Delegates Resolution
To support the position that by the year 2020, the completion of an ASHP-accredited postgraduate-year-one residency should be a requirement for all new college of pharmacy graduates who will be providing direct patient care.

This policy was reviewed in 2011 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Rationale

Pharmacists who engage in direct patient care improve patient outcomes and significantly decrease the overall costs of the health care system, which are rising rapidly. With the continuing development of new dispensing technologies, pharmacy technicians will assume more of the dispensing responsibilities, affording the pharmacists more time to provide clinical services. A postgraduate pharmacy residency enables a pharmacist to maximize the provision of these direct clinical services. Based on the assumption that in the next 20 to 30 years most pharmacists will be providing direct patient care, it is incumbent upon the pharmacy profession to ensure that pharmacists are in a position to make the most effective interventions when selecting, modifying, and monitoring patients' drug therapy regimens.

Although it is true that pharmacy students who graduate meet the minimum competency requirements based on the pharmacy licensing examinations, pharmacists who have completed a residency are better equipped to provide direct patient care because they have the ability to deal with complex clinical situations based on the repetitive practice, preceptor guidance, and the advanced training they receive. For example, some skills in pharmacy school may be obtained in a pharmacy laboratory rather than a real world setting (e.g. training a student to give immunizations). Further, because the advanced practice sites and the clinical involvement of the respective preceptors differ greatly from one school to the next, some students may not be able to obtain the advanced skills they need to provide direct patient care effectively. In addition, two surveys have demonstrated that pharmacists who have completed a residency are more likely to publish newsletter and original research articles and are more likely to be active within national pharmacy organizations. Thus it appears that if all pharmacy graduates completed a residency before engaging in direct patient care, they would have a greater ability to pursue clinical research in addition to being more skilled clinical practitioners. This direction is consistent with both the Joint Commission of Pharmacy Practitioners (JCPP) vision that most pharmacists will provide advanced patient care services by the year 2015 and ASHP's vision for the workforce of the future.

In the beginning of the 20th century, physicians began to realize that medical graduates needed a significant amount of training under skilled practicing physicians before they would become proficient clinical practitioners. New pharmacists also provide better patient care with at least one year of residency training under skilled practitioners. Similar to the medical model, the entire pharmacy education process should be viewed as preparing pharmacists for residency training. The M.D. degree is not considered sufficient training for a medical school graduate to practice patient care. The fact that medical graduates normally complete a four-year B.S. premedical degree, four years of medical school training, and at least a three-year residency allows for the standardization of physician training and the attainment of an appropriate level of competency. The profession of pharmacy would benefit from a similar standardization of training. Furthermore, this will be facilitated if within the next two decades all residencies are accredited and meet specific standards to ensure that the relevant competencies are obtained. Fortunately, the value of pharmacy residency programs has been demonstrated over time and has stimulated a significant increase in accredited residency programs over recent years. An increasing number of pharmacy graduates are also completing one or two years of residency training after graduating in order to bolster their clinical skills and develop confidence.

Another advantage of requiring pharmacists to complete at least a postgraduate-year-one (PGY1) residency is that it would produce a greater number of pharmacists who can fill the increasing number of unfilled pharmacy faculty positions. In 2002, AACP conducted a survey of pharmacy schools that delineated this shortage. Of the 67 schools that responded, 417 faculty positions had not been filled, including 223 in pharmacy practice and 190 in the pharmacy sciences. Furthermore, if a residency is a requirement of practice instead of an option to gain more expertise, it should be easier to garner PGY1 and postgraduate-year-two (PGY2) program support from the government in the future.

This endeavor will face major challenges. By 2020, the pharmacist shortage may be as high as 160,000. The aggregate demand index (ADI) survey, which analyzed data from 1999 to 2003, demonstrated that there is a significant pharmacist shortage throughout the nation and that it has been at least "moderately difficult" to fill these positions. Although the pressure to produce pharmacists for traditional dispensing roles remains high due to the growing demand for these services, it is of paramount importance that colleges and schools of pharmacy focus and intensify their curricula in order to graduate pharmacist professionals who are well versed in pharmacotherapy and prepared to complete a residency in order to prepare themselves for the complex clinical arena. Highly skilled certified pharmacy technicians and technological advances will enable pharmacists to minimize their dispensing roles and afford them time to maximize therapeutic outcomes. Another challenge will be structuring residencies for pharmacists in practice who will want to develop (or demonstrate) their patient-care skills. The most severe challenge, however, will be increasing the number of available residencies to meet the demand. As the transition to the entry-level Pharm.D. degree demonstrated, with years of dedicated effort and innovation, such challenges can be met.

Pharmacy Training Models (1829)
Source: Council on Education and Workforce Development
To promote pharmacy training models that: (1) provide experiential and residency training in interprofessional patient care; (2) use the knowledge, skills, and abilities of student pharmacists and residents in providing direct patient care; and (3) promote use of innovative and contemporary learning models; further,

To support the assessment of the impact of these pharmacy training models on the quality of learner experiences and patient care outcomes.
This policy supersedes ASHP policy 1316.

ASHP Guidelines, Statements, and Professional Policies as an Integral Part of the Educational Process (1706)
Source: Council on Education and Workforce Development
To encourage all educators of the pharmacy workforce to use ASHP statements, guidelines, and professional policies as an integral part of education and training.
This policy supersedes ASHP policy 0705.

Developing Leadership Competencies (1611)
Source: Council on Education and Workforce Development
To work with healthcare organization leadership to foster opportunities, allocate time, and provide resources for pharmacy practitioners to move into leadership roles; further,

To encourage leaders to seek out and mentor pharmacy practitioners in developing administrative, managerial, and leadership skills; further,

To encourage pharmacy practitioners to obtain the skills necessary to pursue administrative, managerial, and leadership roles; further,

To encourage colleges of pharmacy and ASHP state affiliates to collaborate in fostering student leadership skills through development of co-curricular leadership opportunities, leadership conferences, and other leadership promotion programs; further,

To reaffirm that residency programs should develop leadership skills through mentoring, training, and leadership opportunities; further,

To foster leadership skills for pharmacists to use on a daily basis in their roles as leaders in patient care.
This policy supersedes ASHP policy 1518.

Interprofessional Education and Training (1612)
Source: Council on Education and Workforce Development
To support interprofessional education as a component of didactic and experiential education in Doctor of Pharmacy degree programs; further,

To support interprofessional education, mentorship, and professional development for student pharmacists, residents, and pharmacists; further,

To encourage and support pharmacists' collaboration with other health professionals and healthcare executives in the development of interprofessional, team-based, patient-centered care models; further,

To foster documentation and dissemination of outcomes achieved as a result of interprofessional education of healthcare professionals.
This policy supersedes ASHP policy 1014.

Cultural Competency (1613)
Source: Council on Education and Workforce Development
To foster the ongoing development of cultural competency within the pharmacy workforce; further,

To educate healthcare providers on the importance of providing culturally congruent care to achieve quality care and patient engagement.
This policy supersedes ASHP policy 1414.

Education and Training in Health Care Informatics (1317)
Source: Council on Education and Workforce Development
To recognize the significant and vast impacts of health-system information systems, automation, and technology changes on safe and effective use of medications; further,

To foster, promote, and lead the development of and participation in formal health care informatics educational programs for pharmacists, pharmacy technicians, and student pharmacists.
This policy was reviewed in 2017 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Preceptor Skills and Abilities (1201)
Source: Council on Education and Workforce Development
To collaborate with pharmacy organizations on the development of standards to enhance the quality of experiential education and pharmacy residency precepting; further,

To provide tools, education, and other resources to develop preceptor skills.
This policy was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Qualifications of Pharmacy Technicians in Advanced Roles (1203)
Source: Council on Education and Workforce Development
To recognize that highly trained and skilled pharmacy technicians working in advanced roles regularly perform complex and critical medication-use procedures, and that a safe and effective medication-use process depends significantly on the skills, knowledge, and competency of those pharmacy technicians to perform those tasks; further,

To reaffirm that all pharmacy technicians should complete an ASHP-accredited training program, be certified by the Pharmacy Technician Certification Board, and be licensed by state boards of pharmacy; further,

To advocate that beyond those requirements pharmacy technicians working in advanced roles should have additional training and should demonstrate ongoing competencies specific to the tasks to be performed; further,

To advocate that expansion of pharmacy technician duties into expanded, advanced roles should include consideration of potential risk to patients and that ongoing quality assurance metrics should be established to assure patient safety.
This policy was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Quality of Pharmacy Education and Expansion of Colleges of Pharmacy (1108)
Source: Council on Education and Workforce Development
To support the Accreditation Council for Pharmacy Education's continuing role of promulgating accreditation standards and guidelines and engaging in sound accreditation processes to ensure quality in the education provided by colleges of pharmacy; further,

To acknowledge that, in addition to a robust curriculum, access to quality experiential educational sites and the availability of qualified faculty (including preceptors and specialty-trained clinical faculty) are essential determinants of the ability to expand enrollment in existing or additional colleges of pharmacy; further,

To oppose expansion of enrollment in existing or new colleges of pharmacy unless well-designed projections demonstrate that such enrollment increases are necessary to maintain a viable pharmacist workforce.
This policy was reviewed in 2015 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Residency Equivalency (1109)
Source: Council on Education and Workforce Development
To acknowledge the distinct role of ASHP-accredited residency training in preparing pharmacists to be direct patient-care providers; further,

To recognize the importance of clinical experience in developing practitioner expertise; further,

To affirm that there are no objective means to convert or express clinical experience as equivalent to or a substitute for the successful completion of an ASHP-accredited residency.
This policy was reviewed in 2015 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Pharmacy Internships (1110)
Source: Council on Education and Workforce Development
To encourage the National Association of Boards of Pharmacy to develop standardized pharmacy internship hour requirements that would be used uniformly by all state boards of pharmacy; further,

To support structured requirements, goals, and objectives for pharmacy internship experiences, in alignment with requirements for introductory and advanced pharmacy practice experiences; further,

To promote and expand new staffing models that foster expanded roles for pharmacy interns, providing work experiences that build upon their knowledge and help them develop as future pharmacists.
This policy was reviewed in 2015 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

State-Specific Requirements for Pharmacist Continuing Education (1111)
Source: Council on Education and Workforce Development
To support the standardization of state pharmacist continuing education requirements; further,

To advocate that state boards of pharmacy adopt continuing professional development (CPD) as the preferred model for maintaining pharmacist competence and structure continuing education requirements as a component of CPD.
This policy was reviewed in 2015 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Innovative Residency Models (1112)
Source: Council on Education and Workforce Development
To support the development of innovative residency models that meet ASHP accreditation requirements.
This policy was reviewed in 2015 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Employment Classification and Duty Hours of Pharmacy Residents (1008)
Source: Council on Public Policy
To advocate that pharmacy residents should be classified as exempt employees; further,

To advocate that pharmacy residents be subject to duty hour limits (similar to resident physicians) with respect to all clinical and academic activities during their training program in accordance with the Accreditation Council on Graduate Medical Education (ACGME) standards and ASHP accreditation standards for pharmacy residency programs.
This policy was reviewed in 2014 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Pharmacy Student Experiences in Medically Underserved Areas (0913)
Source: Council on Education and Workforce Development
To encourage colleges of pharmacy to require student learning experiences in traditionally medically underserved areas and with diverse patient populations.
This policy was reviewed in 2019 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Continuing Professional Development (0916)
Source: Council on Education and Workforce Development
To endorse and promote the concept of continuing professional development (CPD), which involves personal self-appraisal, educational plan development, plan implementation, documentation, and evaluation; further,

To continue the development of a variety of mechanisms and tools that pharmacists can use to assess their CPD needs; further,

To encourage individual pharmacists to embrace CPD as a means of maintaining their own professional competence; further,

To encourage pharmacy managers to promote CPD as the model for ensuring the competence of their staff; further,

To collaborate with other pharmacy organizations, state boards of pharmacy, accrediting bodies, and regulatory bodies in the development of effective methods for implementing CPD; further,

To strongly support objective assessment of the impact of CPD on pharmacist competence; further,

To endorse the efforts of colleges of pharmacy and ASHP-accredited pharmacy residency programs to teach the principles, concepts, and skills of CPD.

This policy was reviewed in 2019 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Pharmacy Residency Training (0917)

Source: Council on Education and Workforce Development
To continue efforts to increase the number of ASHP-accredited pharmacy residency training programs and positions available.

This policy was reviewed in 2019 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Requirement for Residency (0701)

Source: House of Delegates Resolution
To support the position that by the year 2020, the completion of an ASHP-accredited postgraduate-year-one residency should be a requirement for all new college of pharmacy graduates who will be providing direct patient care.

This policy was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Residency Programs (0704)

Source: Council on Education and Workforce Development
To strongly advocate that all pharmacy residency programs become ASHP-accredited as a means of ensuring and conveying program quality.

This policy was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Communication Among Health-System Pharmacy Practitioners, Patients, and Other Health Care Providers (0510)

Source: Council on Educational Affairs
To foster effective communication (with appropriate attention to patients' levels of general and health literacy) among health-system pharmacy practitioners, patients, and other health care providers; further,

To develop programs to enable pharmacy students, residents, and health-system pharmacy practitioners to self-assess their levels of health literacy and general communication skills; further,

To develop methods with which pharmacy students, residents, and health-system pharmacy practitioners can assess the level of general and health literacy of patients; further,

To disseminate information about resources for students, residents, and health-system pharmacy practitioners to use in working with patients and others having specific communication needs.

This policy was reviewed in 2014 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Licensure for Pharmacy Graduates of Foreign Schools (0323)

Source: Council on Legal and Public Affairs
To support state licensure eligibility of a pharmacist who has graduated from a pharmacy program accredited by the Accreditation Council for Pharmacy Education (ACPE) or accredited by an ACPE-recognized accreditation program.

This policy was reviewed in 2017 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Public Funding for Pharmacy Residency Training (0325)

Source: Council on Legal and Public Affairs
To support legislation and regulation that ensures public funding for accredited pharmacy residency programs consistent with the needs of the public and the profession; further,

To oppose legislation or regulation involving reimbursement levels for graduate medical education that adversely affects pharmacy residencies at a rate disproportionate to other residency programs.

This policy was reviewed in 2017 by the Council on Public Policy and by the Board of Directors and was found to still be appropriate.

Residency Training for Pharmacists Who Provide Direct Patient Care (0005)

Source: Council on Educational Affairs
To recognize that optimal direct patient care by a pharmacist requires the development of clinical judgment, which can be acquired only through experience and reflection on that experience; further,

To establish as a goal that pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience.

This policy was reviewed in 2014 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.

Career Counseling (8507)

Source: Council on Educational Affairs
To urge colleges of pharmacy to develop career counseling programs to make students aware of postgraduate career options, including residency training and career paths in various types of practice; further,

To urge that career counseling occur in a structured manner early in the curriculum and be continued throughout the curriculum; further,

To urge practitioners in various organized health care settings to make themselves available to colleges of pharmacy for participation in both structured and unstructured career counseling.

This policy was reviewed in 2016 by the Council on Education and Workforce Development and by the Board of Directors and was found to still be appropriate.