ASHP ACCREDITATION STANDARD
FOR POSTGRADUATE RESIDENCY PROGRAMS

Introduction
The ASHP Accreditation Standard for Postgraduate Residency Programs (The Standard) represents the harmonization of the PGY1 Pharmacy, PGY1 Community-based Pharmacy, PGY1 Managed Care Pharmacy, and PGY2 Pharmacy Accreditation Standards into a single Standard that establishes criteria for the training of pharmacists to achieve professional competence in the delivery of patient-centered care, leadership, and pharmacy services. The Standard was developed in a manner that supports PGY1 and PGY2 postgraduate training as described by the following Purpose Statements:

**PGY1 Purpose:** PGY1 residency programs build upon Doctor of Pharmacy (PharmD) education and outcomes to develop pharmacist practitioners with knowledge, skills, and abilities as defined in the educational competency areas, goals, and objectives. Residents who successfully complete PGY1 residency programs will be skilled in diverse patient care, practice management, leadership, and education, and be prepared to provide patient care, seek board certification in pharmacotherapy (i.e., BCPS), and pursue advanced education and training opportunities including postgraduate year two (PGY2) residencies.

**PGY2 Purpose:** PGY2 residency programs build upon Doctor of Pharmacy (Pharm.D.) education and PGY1 pharmacy residency training to develop pharmacist practitioners with knowledge, skills, and abilities as defined in the educational competency areas, goals, and objectives for advanced practice areas. Residents who successfully complete PGY2 residency programs are prepared for advanced patient care or other specialized positions, and board certification in the advanced practice area, if available.

Application of the Standard
The requirements defined in The Standard serve as the basis for evaluating all residency programs and will be used in conjunction with the Competency Areas, Goals, and Objectives for individual program types to assess residency programs’ fulfilment of the corresponding Purpose.

The Standard describes the criteria used in evaluation of programs that apply for accreditation and reaccreditation of their programs. The policies governing the accreditation process and procedures for seeking and maintaining accreditation are described in the ASHP Regulations on Accreditation of Pharmacy Residencies.

The accreditation process is conducted under the authority of the ASHP Board of Directors and is supported through formal partnerships with several other pharmacy associations including the American Pharmacists Association (APhA) and the Academy of Managed Care Pharmacy (AMCP).

The Guidance provides interpretation of The Standard. Guidance and How It Will Be Surveyed describes how compliance with The Standard will be evaluated by accreditation surveyors.
Overview of the Standards

Standard 1: Recruitment and Selection of Residents

Standard 1 provides guidance to residency programs for the recruitment and selection of residents by defining candidate eligibility requirements along with the policies and procedures necessary to the recruitment process. The goal of the selection process is to ensure selected candidates will be successful in the training environment, attain professional competence, contribute to the advancement of profession of pharmacy, and support the organizations’ mission and values.

Standard 2: Program Requirements and Policies

Standard 2 details the specific requirements for residency program policies; materials to be provided to candidates invited to interview; resident financial support and resources; and, requirements of ASHP Regulations on Accreditation of Pharmacy Residencies and ASHP Duty-Hour Requirements for Pharmacy Residencies.

Standard 3: Structure, Design, and Conduct of the Residency Program

Standard 3 defines required components of program structure, design, and conduct. It is important that the program’s structure and design enable residents to achieve the purpose of the residency program through skill development in the program’s required competency areas. Requirements for oversight of residents’ development, formative and summative evaluations, and self-assessment are defined along with guidelines for continuous program improvement.

Standard 4: Requirements of the Residency Program Director and Preceptors

Standard 4 defines eligibility and qualification requirements for residency program directors (RPDs) and preceptors as well as requirements for the residency advisory committee (RAC) and continuous preceptor development. RPDs and preceptors are critical to the success of both residents and the residency program and are the foundation of residency training. They serve as role models for residents through their professionalism and commitment to advancing the profession of pharmacy.

Standard 5: Pharmacy Services

Standard 5 serves as a guide to best practices across the continuum of pharmacy practice environments and focuses on the key elements of a well-managed department that are applicable to all practice environments. Each standard applies to all practice environments, unless otherwise indicated [IN BLUE].

Glossary of Terms and Acronyms can be found at the end of the document.
Standard 1: Recruitment and Selection of Residents

1.1 Programs have a documented procedure that is used by all involved in the recruitment, evaluation and ranking of applicants. The procedure includes:

1.1.a Description of methods for recruitment of a diverse and inclusive applicant pool.

1.1.b Pre-determined, objective criteria for determining which applicants shall be invited to interview.

1.1.c Pre-determined, objective criteria for evaluating each applicant’s interview performance.

1.1.d Description of how the rank order of applicants for the Match is determined.

1.1.e Description of Phase I and Phase II match procedures.

1.1.f Description of early commit procedures for PGY2 programs, if applicable.

Guidance
- 1.1 Evaluation and ranking procedure appears in the residency manual or other readily available residency or pharmacy department documents.
- 1.1 Applicant selection process should include the residency program director and others involved in the conduct of the residency program.
- 1.1.a Recruitment identifies and engages individuals underrepresented in the profession of pharmacy. Additionally, if the patient population served by the program’s organization is an underserved population, then the applicant pool should represent the organization’s population.
- 1.1.b and 1.1.c Programs ensure objective criteria are free from bias and methods are established to reduce and eliminate implicit bias throughout the continuum of the recruitment, selection, and ranking process. *(See Diversity Appendix for further information and examples. Note: Diversity Appendix is in development)*
- 1.1.b Procedures include information on how the academic performance of applicants from pass/fail institutions are evaluated, if GPA is part of the applicant selection criteria.
- 1.1.b A documented applicant screening rubric.
- 1.1.c A form with pre-determined interview questions and defined criteria for rating applicant’s interview performance.

How it will be surveyed
Review of:
- Formal, documented procedure, including the programs efforts to recruit a diverse applicant pool
- Tools and rubrics used
- Recruitment materials
- Predetermined criteria used to select applicants to interview and rank
- Discussion with RPD and others involved in the applicant selection process
1.2 Programs’ applicant selection process ensures the following:

1.2.a Applicants to programs are graduates or candidates for graduation from an ACPE accredited degree program (or one the in process of pursuing accreditation) or have a Foreign Pharmacy Graduate Examination Committee (FPGEC) certificate from the NABP.

1.2.b Applicants are licensed or eligible for licensure in the state or jurisdiction in which the program is conducted.

1.2.c For PGY2 residencies, applicants are completing or have completed an ASHP-accredited or candidate-status PGY1 residency.

1.2.d Applicants to international programs are graduates or candidates for graduation from a pharmacy degree program that is a minimum of five years in length.

1.2.d.1 Programs ensure that residents graduating from pharmacy degree programs other than a 6-year Doctor of Pharmacy (Pharm.D.) degree program have necessary baseline knowledge and skills to achieve objectives within the 12-month time frame and modify the residency program, when needed, to ensure residents have sufficient time in the residency to achieve program requirements.

1.2.d.2 Applicants to international pharmacy residencies are eligible for licensure or equivalent designation (e.g., registered) in the country in which the program is conducted.

Guidance

- 1.2 Process appears in the residency manual or other readily available residency or pharmacy department documents.
- 1.2.a An FPGEC certificate indicates that a candidate graduated from a pharmacy school outside of the US and is eligible for pharmacist licensure. FPGEC status is not related to citizenship or VISA sponsorship.
- 1.2b Jurisdiction pertains only to federal programs (e.g., Veterans Administration, DOD, USPHS, and IHS) in which pharmacists may practice as long as they maintain license in any state or U.S. territory.

How it will be surveyed:

Review of:

- Applicant selection procedure
- Predetermined criteria used to select applicants to interview and rank
- 1.2.d.1 Discussions with RPD, preceptors and residents as well as reviewing program structure, learning experience descriptions and deliverables from residents from 5-year degree programs (for international programs only)

1.3 The residency program abides by the Rules for the ASHP Pharmacy Resident Matching Program.

Guidance

- The following residency programs are not required to offer positions through the Resident
Matching Program per the Rules for the ASHP Pharmacy Resident Matching Program:
- IHS residency positions
- USPHS and DOD residency positions offered exclusively to commissioned pharmacy officers

Residency programs not required to offer positions through the ASHP Resident Match Program, as listed above, are required to report the number positions filled annually to the ASHP Accreditation Services Office by April 1st. This may be done by each individual program or collectively for programs utilizing the same process for hiring exempt residency positions (i.e., IHS). The date by which applicants accept or decline residency positions offered through the IHS match process occurs prior to the initial date applicants may submit Rank Order Lists for Phase I of the Match.

Residency programs conducted outside of the US and US territories are exempt from the Match but can choose to participate, if desired.

How it will be surveyed
Review of:
- Documented applicant selection procedure
- Predetermined criteria used to select applicants to interview and rank
- Discussion of applicant selection procedure with residency program director (RPD), residency advisory committee (RAC) members, and preceptors

Standard 2: Program Requirements and Policies

2.1 The minimum term of resident appointment is 52 weeks.

2.2 All leave, excluding professional leave, cannot exceed a combined total of 30 days without requiring extension of the program. Training is extended to make up any absences exceeding 30 days and extension is equal to the content and time missed.

2.2.a Program policies define the amount of vacation, sick, holiday, professional, and extended leaves allowed.

2.2.b Program policies define whether extension of the program is allowed for residents who take leave in excess of 30 days, excluding professional leave.

2.2.b.1 Programs that permit extension of the program must specify the maximum length allowed and the status of salary and benefits during the extension.

2.2.b.2 For programs that do not permit extensions, policies state that residents taking leave in excess of 30 days will not receive a certificate of completion.

Guidance
- 2.2 When training is extended to make up absence, the training to be “made up” is accomplished via an experience (or experiences) reflective of the content and length to what was missed (the training plan is equal to both the content missed and the time missed).
- 2.2.a Professional leave includes conference time and interview days, if allowed by the program

How it will be surveyed
- Review of program’s leave policies
2.3 Programs ensure compliance with the ASHP Duty-Hour Requirements for Pharmacy Residencies through the development of program policies, processes, or program documents as it applies to the following:

2.3.a The web link for the ASHP Duty-Hour Requirements for Pharmacy Residencies is included in the program’s duty-hour policy.

2.3.b A process for monitoring compliance includes:

2.3.b.1 Documenting compliance with all requirements including hours worked, hours free of work, moonlighting, and frequency of all on-call programs.

2.3.b.2 Monthly tracking of compliance.

2.3.b.3 Process for assessing instances of non-compliance and actions to be taken to prevent exceeding duty-hours.

2.3.c Documentation of moonlighting policy.

2.3.d Documentation of on-call programs, if applicable.

Guidance

- 2.3 Residency program directors and preceptors have the professional responsibility to provide residents with a sound training program that must be planned, scheduled, and balanced with concerns for patients’ safety and residents’ well-being.

- 2.3 Program policies appear in the residency manual (written or electronic) or other readily available pharmacy department documents.

- 2.3.a The web link is included to assure that programs and residents have access review the most up to date requirements.

- 2.3.b.1 Tracking of residents’ hours to ensure they have not exceeded duty-hour limits may be accomplished by attestations (written or generated from PharmAcademic™), work hours/resident schedules, or timesheets.

- 2.3.c Moonlighting policy should state whether moonlighting is allowed and if yes, what type (e.g., internal, external). The policy should include a structure for approval and actions that will be taken if moonlighting affects the resident’s performance.

- If the program includes on-call programs, the type (e.g., in-house, call from home) and process is documented.

How it will be surveyed

Review of:

- Documentation of duty-hours and moonlighting policies, processes, or program materials
- Documentation of monthly attestations, work hours/schedules or timesheets
- Discussions related to duty-hour practices and procedures

2.4 Requirements for Licensure

2.4.a Residents are licensed to practice pharmacy in the program’s state or jurisdiction prior to or within 120 days after the program start date.
2.4.b For international pharmacy residencies, residents are licensed to practice pharmacy in the program’s country prior to or within 120 days after the program start date.

2.4.c Licensure policies include a licensure deadline and information about how the program will be modified if the resident is not licensed within 120 days to ensure residents complete at least two-thirds of their residency as a licensed pharmacist.

**Guidance**
- Program policies appear in the residency manual (written or electronic) or other readily available pharmacy department documents.
- 2.4c:
  - Residents not licensed within 120 days after the program’s start date must either be dismissed from the program or the resident’s term of appointment extended by the number of days the resident is without licensure past the 120-day deadline.
  - For PGY1/PGY2 combined programs, residents not licensed within 120 days after the start of the program must either be dismissed from the program or the resident’s term of appointment for their PGY1 year extended by the number of days the resident is without licensure past the 120-day deadline. Further, the resident’s PGY2 year start date must be delayed until after the resident has completed the PGY1 year, and the resident’s PGY2 end date must be adjusted to ensure the PGY2 program is 52 weeks in duration.
  - In a 52-week residency program, 120 days (17 weeks) is one-third of the program, therefore residents must complete at least 35 weeks of their residency as a licensed pharmacist to meet the two-thirds requirement.
  - Programs that offer extensions or suspensions specify the status of salary and benefits during that period. If the program is extended, policies must describe the maximum extension allowed and whether the resident will be paid during the extension.
  - If the program chooses to suspend the resident until they are licensed and re-start the program, the maximum length of suspension is defined and along with the status of salary and benefits.
  - Programs may choose a required licensure date that is sooner than 120 days as long as all policies and requirements are clear.
  - Program policies for extensions, suspensions, and extenuating circumstances ensure that the resident is licensed for two-thirds of the 52-week training period.

**How it will be surveyed**
- Review of licensure policy in program materials
- Discussion with RPD and pharmacy leadership

2.5 Requirements for successful completion of the program are documented and include the following:

2.5.a Requirements for overall achievement of educational objectives for the residency.

2.5.a.1 The threshold related to educational objectives that would prevent awarding a certificate of completion is defined.

2.5.b List of required deliverables related to educational objectives.

2.5.c Appendix requirements, if the program’s associated Competency Areas, Goals, and Objectives include a required appendix.

2.5.d Other requirements as defined by the program.
2.5.a In PharmAcademic™, achievement of objectives for the residency is designated as “ACHR”. Examples of ACHR requirements include but are not limited to: Program designates percent or number of objectives that must be achieved for residency (ACHR), identifies specific objectives that must be achieved for residency (ACHR), or a uses a combination of the two methods.

2.5.b Required deliverables are different for each type of residency program. An example of a required deliverables for all residencies is a final project report. See ASHP website for required deliverables for each specific type of residency program. (Note: in development)

2.5.d Possible examples of other requirements defined by programs include minimum staffing requirements, and completion of a teaching certificate.

How it will be surveyed
Review of:
- List of successful completion requirements in program’s documents
- Review of deliverables from residents who successfully completed the residency program

2.6 A residency-specific remediation/disciplinary policy is documented and includes actions taken for residents who fail to progress and any resident-specific behaviors that trigger the organization’s disciplinary process.

Guidance
- The residency remediation/disciplinary policy is intended to address issues that are not specifically covered by the organization’s disciplinary policy. At minimum, the policy addresses the procedure followed for resident(s) failing to progress up to and including when failure to progress would result in dismissal from the residency program.
- Programs can link residency-specific policy to the organization’s disciplinary policy.
- Residency-specific policies should be reviewed by the Human Resources department to ensure consistency with organization’s policies.

How it will be surveyed
Review of:
- Residency-specific remediation/disciplinary policy
- Discussion with RPD

2.7 PGY2 programs follow a documented procedure for verifying incoming residents successfully completed their ASHP-accredited or candidate-status PGY1 program.

2.7.a Procedure includes timeframe for verification and consequences for incoming residents not completing their PGY1 programs.

Guidance
- 2.7 Options for verification include, but are not limited to, direct communication with PGY1 RPD, graduate tracking in PharmAcademic™, or certificate of PGY1 completion.

How it will be surveyed
- Review of procedure

2.8 The program director provides applicants invited to interview with the following residency information and policies at the time the invitation to interview is extended:

2.8.a Leave policies.
2.8.b Duty-hour policies.

2.8.c Licensure policy.

2.8.d Requirements for successful completion of the program.

2.8.e Residency-specific remediation/disciplinary policy.

2.8.f Start and end date of residency.

2.8.g Stipend and benefit information.

**Guidance**
- 2.8 In lieu of emailing policies, programs can provide applicants a link to their policies.
- 2.8.a Leave policies include policies specified in Standard 2.2.a.
- 2.8.g Benefit information includes vacation, holiday, professional, and sick leave allotment and whether health insurance is available.

**How it will be surveyed**
- Review of program policies and information provided to candidates invited to interview

2.9 Within 30 days of the Match, the program contacts each matched candidate in writing and requests candidates to confirm and document their acceptance of the Match by return correspondence by a date determined by the program but prior to the start of the residency program. At that time:

2.9.a The program also provides general information about the hiring process including pre-employment requirements.

2.9.b Matched PGY2 candidates are provided information related to verification of PGY1 residency program completion.

2.10 The RPD or designee reviews program policies with matched candidates and acceptance is documented prior to or within 7 days from the start of the residency.

**Guidance**
- 2.9 Documented acceptance may be in the form of an email exchange.
- 2.9.a Pre-employment requirements may include human resources requirements such as application for employment, drug testing, criminal record check, health screenings, and immunizations.
- 2.10 Program policies include those listed in 2.8.
- 2.10 The program policies are provided again so the candidate can formally accept them.

**How it will be surveyed**
- Review of an example of the communication from the program to each matched candidate and documentation of candidates’ acceptance of the Match results.
- Review of information provided to Matched candidates (e.g., pre-employment information).
- Review of program policies provided to Matched candidates.
- Review of documented acceptance of program policies by Matched candidates.
2.11 Programs provide residents with a residency manual.

Guidance
- Residency manuals include information on the practice site, program structure, program participants and roles, completion requirements, residency policies (or information on where located), program’s overall evaluation strategy including evaluations required and the defined rating scale for summative evaluations (see Standard 3), and other information pertinent to residents (e.g., residency project guidelines).

How it will be surveyed
- Review of program’s manual

2.12 The residency program provides financial support and adequate resources to residents to complete residency requirements including:

2.12.a Stipend and benefits

2.12.b An area in which to work, that is safe and conducive to concentrating without constant interruptions.

2.12.c Access to technology necessary to perform work functions.

   2.12.c.1 For residents working remotely, appropriate technology and equipment is provided to allow residents to fulfill program responsibilities.

2.12.d Financial support for required professional meeting attendance

Guidance
- 2.12.c Examples of technology include a laptop or work station, access to clinical information systems, databases, and references.
- 2.12.c.1 Technology and equipment provided is comparable to that provided to the organization’s other remote workers.
- 2.12.d Examples of required meetings include pharmacy association meetings and regional residency conferences.

How it will be surveyed
Review of:
- Promotional materials
- Program’s manual
- Acceptance letter/agreement/contract and attachments
- Tour of residents’ work space
- Resident interview

2.13 The RPD will award a residency completion certificate only to those who complete the program’s requirements.

2.13.a Residents’ completion of the program’s requirements is documented by the RPD or designee.

2.13.b The requirements for awarding a certificate match the program’s documented completion requirements.
2.14 The certificate provided to residents who complete the program’s requirements is issued in accordance with the provisions of the *ASHP Regulations on Accreditation of Pharmacy Residencies*.

2.14.a The certificate is signed by the RPD and the chief executive officer or appropriate executive of the sponsoring organization.

2.14.b The certificate includes the required language as outlined in the *ASHP Regulations on Accreditation of Pharmacy Residencies*:

2.14.b.1 Organization name

2.14.b.2 Residency program type

2.14.b.3 City and state where located

2.14.b.4 Accreditation status (i.e., ASHP Accredited or ASHP Candidate-Status)

2.14.c For PGY1 Managed Care Residency Programs, the certificate references that the program is accredited by ASHP in partnership with AMCP.

2.14.d For PGY1 Community-Based Residency Programs, the certificate references that the program is accredited by ASHP in partnership with APhA.

Guidance

- 2.14 Certificates include the following language per *ASHP Regulations on Accreditation of Pharmacy Residencies*: “The (residency program type, such as PGY-1 Pharmacy Residency) conducted by (organization name, city, and state) is accredited (or in candidate status for accreditation) by ASHP.”

Guidance

- See Standard 2.15 for definition of sponsoring organization.
• 2.14.b.2 Following are the approved names for program type:
  o PGY1 Pharmacy Residency
  o PGY1 Community-Based Pharmacy Residency
  o PGY1 Managed Care Pharmacy Residency
  o PGY2 (insert type as listed in title of Competency Areas, Goals, and Objectives document) Residency

• 2.14.b.2 Modifiers to the type of program (e.g., PGY1 Pharmacy Residency in Ambulatory Care) are not allowed.

• 2.14.b.3 For international programs, the certificate includes city and country where located.

How it will be surveyed
• Review of certificate for signatures and wording.
• Candidate status programs provide a draft of current certificate and also a draft of certificate to be issued once accreditation is conferred.

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

2.15.a Program uses the approved program-type name.

2.15.b Program uses PharmAcademic™ for residency program management and maintenance of certain program documents including:
  2.15.b.1 Program’s taught and evaluated (“TE”) grid
  2.15.b.2 Learning experience descriptions
  2.15.b.3 Residents’ schedules
  2.15.b.4 Evaluations listed in Standard 3
  2.15.b.5 Residents’ development plans
  2.15.b.6 Resident close-out documentation
  2.15.b.7 Initial employment information for residents who successfully completed the program

2.15.c A record of each Matched Candidates’ documented acceptance of program policies; copy of each resident’s licensure, deliverables, documentation of completion requirements; and each resident’s signed residency certificate provided at completion of program is kept since last accreditation site survey.

Guidance
• 2.15.a The following are the accepted names for PGY1 and PGY2 programs. These names are used in residents’ certificates and consistently throughout all promotional materials, program materials, and web sites.
  PGY1 Pharmacy
  PGY1 Managed Care Pharmacy
  PGY1 Community-Based Pharmacy
PGY2 (insert type as listed in title of Competency Areas, Goals, and Objectives document)
Residency

Variation in naming of the program types listed above is not allowed and would be considered non-compliant with the regulations on accreditation of pharmacy residencies. (e.g., adding modifiers such as “ambulatory focus,” “pediatric emphasis”, etc. is specifically prohibited.) Program descriptions should contain information regarding the practice setting but indicating that information in the name of the program is prohibited.

- 2.15.c Regulation (VII.B.): “Records (to include, residents’ applications, residents’ acceptance letters, residents’ plans, all evaluations, residents’ projects, and copies of certificates) for residents trained by an ASHP-accredited program since the last site survey (i.e., up to eight years) must be maintained and available to the survey team for review. These records may be maintained electronically, as long as they can be easily accessed, if requested by the survey team.”

How it will be surveyed
- Review of promotional materials for the residency programs including printed and web-based information
- Review of PharmAcademic™
- Review of records of past residents to determine if they have been maintained for the appropriate length of time as specified in the ASHP Regulations on Accreditation of Pharmacy Residencies.

2.16  Responsibilities of the Residency Program Operator (The “Operator”)

2.16.a  When the Operator and one or more organizations share responsibility for the financial and/or management aspects of the residency (e.g., college of pharmacy, health system):

  2.16.a.1  The Operator maintains authority for the residency program and responsibility for meeting accreditation standards.

  2.16.a.2  The Operator maintains a signed agreement with the additional organization(s) that clearly defines the responsibilities for all aspects of the residency program including:

    2.16.a.2.a  Designation of a single RPD

    2.16.a.2.b  RPD responsibilities

    2.16.a.2.c  RPD’s accountability to the Operator

    2.16.a.2.d  A documented mechanism that designates and empowers the RPD to achieve consensus on the evaluation and ranking of applicants for the residency

    2.16.a.2.e  Mechanism for designating practice site coordinators for organizations where the RPD does not maintain an active practice
2.16.a.2.f  Method for coordinating the conduct of the residency program within all organizations

2.16.a.2.g  Method of evaluation to ensure terms of agreement are met

Guidance

- 2.16 Residency Program Operator: An organization (e.g., hospital, college of pharmacy, corporation, federally qualified healthcare center (FQHC), outpatient clinic, or other business entity) that assumes primary responsibility for coordinating and administering the residency program training curriculum in accordance with the Standard. The residency program operator (the “operator”) is charged with ensuring that residents’ experiences are educationally sound and are conducted in a quality practice environment. The operator is also responsible for submitting the accreditation application and ensuring periodic evaluations of the program are conducted.

- 2.16a If several organizations share responsibility for the financial and/or management aspects of the residency (e.g., hospital, college of pharmacy, corporation, federally qualified healthcare center (FQHC), outpatient clinic, and other business entity), the organizations must mutually designate one organization as the Operator. The Operator may or may not provide financial support. However, if an Operator seeks CMS pass through funding for a PGY1 residency program, the Operator must maintain full administrative and financial control of the residency program inclusive of training curriculum and resident salary. This relationship must be agreed to in writing and signed by all parties (i.e., affiliation agreement) and comply with Standard 2.16.a.2.

How Surveyed

- Review of residency agreements
- Discussion with RPD

2.17 Multiple practice-site residencies comply with the ASHP Regulations on Accreditation of Pharmacy Residencies.

Guidance

- Refer to the ASHP Regulations on Accreditation of Pharmacy Residencies. (Note: Regulations are currently under review and revision)

How Surveyed

- Review of residency agreements, as applicable
- Discussion with RPD

Standard 3: Structure, Design, and Conduct of the Residency Program

3.1 Program Structure and Design

3.1.a The program structure is documented and includes:

3.1.a.1 A list of all required and elective learning experiences.

3.1.a.2 Duration of each learning experience.

3.1.a.3 Time commitment for each learning experience that is twelve or more
weeks in duration, where the program has allotted dedicated time for the learning experience.

3.1.a.4 A learning experience that facilitates orientation of the resident to the residency program and practice environment at the beginning of the residency.

Guidance
- 3.1.a Structure is described consistently across all program materials.
- 3.1.a.1 All listed learning experiences have a fully developed learning experience description documented in PharmAcademic™.
- 3.1.a.1 Promotional and program materials list only elective learning experiences that have been fully developed. However, promotional materials may include a statement that “other elective learning experiences may be developed based on resident interest and preceptor availability”.
- 3.1.a.1 Programs are not required to offer elective learning experiences.
- 3.1.a.2 The structure includes the duration (e.g., 6 weeks, 3 months, 52 weeks) of each learning experience. Ranges in duration for learning experiences should be limited to no more than 2 weeks variation (e.g., 4-6 weeks). The use of ranges for multiple learning experiences should not impact the overall basic structure of the program or impact the number of elective learning experiences available for each resident.
- 3.1.a.2 Programs can lengthen a learning experience due to conferences, vacations, interviews, or other time away from the learning experience.
- 3.1.a.3 If specific time is allotted on a scheduled basis (e.g., 4 hours every Tuesday morning, half-day every other Friday, one day per month), the schedule is clearly documented.
- 3.1.a.3 Examples:
  - Critical care: 6 weeks,
  - Hepatitis clinic: 12 weeks, 0.5 day every Tuesday
  - Staffing: 40 weeks, 10-hour shifts every other weekend
  - Project: 48 weeks, 1 day per month is a dedicated project day
- See ASHP web site for examples of program structure documentation. (Note: In development)
- 3.1.a.4 The initial learning experience scheduled for residents includes orientation to the residency program and practice environment. Orientation to the residency program includes, at minimum, orienting residents to the:
  - Residency manual (see Standard 2.11 guidance for required contents of residency manual).
  - Residency’s purpose, as documented in the introduction to The Standard
  - Accreditation standards.
  - Competencies, goals, and objectives applicable to the residency program.
  - Description of required and, if applicable, elective learning experiences.
  - Organization’s process for reporting issues around harassment and inappropriate behavior, if not covered by the organization’s orientation for new employees.
- Note: For PGY2 residents who completed their PGY1 year at the same practice site, only orientation to the residency program is required.

How it will be surveyed
- Review of documented structure in program and promotional materials
- Review of residents’ schedules in PharmAcademic™
- Review of program’s taught and evaluated (TE) grid in PharmAcademic™
3.1.b Competency Areas, Goals, and Objectives

3.1.b.1 The program’s structure supports the program purpose and facilitates achievement of all required objectives.

3.1.b.1.a All required objectives are assigned to at least one required learning experience or a sequence of learning experiences to allow sufficient practice for their achievement.

3.1.b.1.b If the competency areas, goals, and objectives include a required Appendix, the program structure ensures the requirements listed in the Appendix are met.

3.1.b.1.c The program’s required learning experiences, as reflected in the program’s structure, are scheduled for all residents.

Guidance

- 3.1.b.1.a The number of times each required objective needs to be assigned to required learning experiences depends on the type and complexity of the objective and each program’s design and structure.
- 3.1.b.1.a Elective objectives are objectives that are not required by the Competency Areas, Goals, and Objectives. Programs may select elective objectives for the program, a specific learning experience, or a specific resident.
- 3.1.b.1.b The program reviews the appendix requirements and considers where they are best addressed in the program structure.
- 3.1.b.1.b For community-based programs, the following patient care activities are required as part of residency training regardless of the type of practice at the home-base practice site or other practice sites used in the training of residents *:
  - Medication management including comprehensive medication management and targeted medication intervention services with follow-up
    The total number of CMRs completed by the resident includes at least three chronic disease states from the following list: *Alzheimer disease*, *Arthritis*, *Chronic heart failure*, *Diabetes*, *Dyslipidemia*, *End-stage renal disease*, *Hypertension*, *Mental health*, *Respiratory Diseases*
  - Health and wellness
    The resident gains experience with at least three health and wellness services during the residency program. Examples of health and wellness services may include: *Screenings of blood glucose, blood pressure, cholesterol, osteoporosis, etc.*
    *Wellness programs including smoking cessation, weight loss, pain management, etc.*
    *Health fairs*, *Medication take-back*
    *Disease prevention patient education classes*
    *Naloxone*
    *Nutrition*
  - Immunizations
    Residents are required to administer at least three types of immunizations.
  - Disease state management incorporating medication management
Training of residents with regard to disease state management includes at least three of the following chronic disease states: *Alzheimer disease* *Arthritis* *Chronic heart failure* *Diabetes* *Dyslipidemia* *End-stage renal disease* *Hypertension* *Mental health* *Respiratory Diseases*

- **Care transitions incorporating medication reconciliation and medication management**
  Residents are provided training and gain experience to be able to: *identify patients undergoing care transition* *perform medication reconciliation (updated medication list and a medication action plan consistent with comprehensive medication therapy management (MTM))* *develop transition of care plan* *provide patient education (care transition counseling)* *conduct follow up and monitor the patient care transition plan* *take appropriate actions and communicate with appropriate members of the health care team, when applicable*

- **Patient-centered medication distribution**

*Follow detailed training requirements in the Appendix of the PGY1 Community-Based Competency Areas, Goals, and Objectives. (Note: In development/HYPERLINK when completed)*

**How it will be surveyed**
- Review of documented structure in program and promotional materials.
- Review of program’s taught and evaluated (TE) grid in PharmAcademic™.
- 3.1.b.1.b The following will be reviewed for the community-based pharmacy patient care requirements:
  - Documentation of CMRs and TMRs completed by residents, including personal medication records (PMR), medication-related action plans (MAP), patient care notes on intervention and/or referral, and documentation of follow-up when needed.
  - Patient care services grid

3.1.c  Program Design Requirements for PGY1 and Direct Patient Care PGY2 Residencies

3.1.c.1 Residents gain experience and independent practice with a variety of disease states and conditions and a diverse range of patients’ medication treatments and health-related needs.

3.1.c.2 Residents gain experience in recurring follow-up of patients assigned, relative to the practice environment.

3.1.c.3 Residents spend two thirds or more of the program in patient care activities.

**Guidance**
- 3.1.c.1-3.1.c.3
  - PGY1 includes PGY1 Managed Care Pharmacy, PGY1 Community-Based Pharmacy and PGY1 Pharmacy residencies.
  - PGY2 Direct Patient Care Residencies encompass all PGY2 residencies that include “Competency Area R1: Patient Care”, as part of the required competency areas, goals, and objectives for the residency program.
- 3.1.c.2
  - For ambulatory, managed care, and community-based pharmacy settings, residents gain practice and experience in longitudinal patient care delivery and the development of extended patient relationships (i.e., care includes the initial patient encounter and multiple follow-up visits during the residency year).
For acute care settings, residents may gain experience in taking care of patients during their stay relative to the specific learning experience. For example, residents on a critical care learning experience, care includes routine follow-up throughout the patient’s stay in the ICU. It is not required for acute care settings to include an ambulatory care learning experience for residents to gain experience in recurring patient follow-up.

- 3.1.c.3 Patient Care Activities are activities performed by pharmacists with the intent of contributing to positive pharmacotherapeutic and health outcomes of individual patients. Care is in collaboration and communication with other members of the health care team with responsibilities for the individual patient. Communication may be face-to-face, telephonically, virtually, or in writing.

**How it will be surveyed**
- Review of the program’s structure, residents’ schedules, and learning experience descriptions.
- Discussion with preceptors, residents, and other health care providers.

3.1.c.4 PGY1 Residencies Only: No more than one-third of the twelve-month residency program may focus on a specific disease state or population.

**Guidance**
- 3.1.c.4 Examples of patient disease states include hypertension, diabetes, hepatitis C, and hyperlipidemia.
- 3.1.c.4 Examples of populations include: oncology, critical care, cardiology, infectious diseases, patients with inflammatory diseases, and anticoagulation clinic patients.

**How it will be surveyed**
- Review of the program’s structure, residents’ schedules, and learning experience descriptions.
- Discussion with preceptors, residents, and other health care providers.

3.2 Learning Experiences

3.2.a Learning experience descriptions are documented and include:

- 3.2.a.1 A general description, including the practice area
- 3.2.a.2 The role of pharmacists in the practice area
- 3.2.a.3 Expectations of residents
- 3.2.a.4 Resident progression
- 3.2.a.5 Objectives assigned to the learning experience
- 3.2.a.6 For each objective, a list of learning activities that facilitate its achievement

**Guidance**
- 3.2.a Preceptors are involved in the development of learning experience descriptions.
- Learning experience descriptions are documented in PharmAcademic™.
- 3.2.a.1 The description of the practice area may include types of patients, members of the healthcare team, patient care focus, and typical patient load. A description of the practice area is not required for non-direct patient care learning experiences.
• 3.2.a.2 The role of the pharmacist describes the pharmacist’s (not the residents) daily responsibilities in the practice area, for both direct patient and non-direct patient care learning experiences.
• 3.2.a.3 In addition to daily or weekly responsibilities, expectations of residents may include required presentations, topic discussions, projects, assignments, and meeting attendance.
• 3.2.a.4 Resident progression describes the expectation for resident skill development over the duration of the learning experience. Progression timelines are documented in each learning experience. If more than one learning experience in the same practice area is offered (e.g., Patient Care 1 and Patient Care 2), the expected progression reflects advanced expectations.
• 3.2.a.5 At least one objective is assigned to each learning experience.
  o 3.2.a.6 Learning activities are specific to the practice area, unique to the objective, and developed at the cognitive learning level (Bloom’s Taxonomy) associated with the objective. Note: Criteria associated with each objective are meant to guide the preceptor on assessing the resident and not to be used as learning activities. Learn more at: http://www.ashpmedia.org
  o See learning experience description example and example activities on ASHP website. (Note: In development)

How it will be surveyed
• Review of learning experience descriptions in PharmAcademic™.

3.2.b At the beginning of each learning experience, preceptors orient residents to the experience.

Guidance
• 3.2.b Orientation to the learning experience includes review of the learning experience description and:
  o How and when preceptors will provide feedback to the resident.
  o How and when residents will provide preceptor and learning experience feedback.
  o Review of expectations for documented resident self-evaluation, if required for the learning experience.

How it will be surveyed
• Discussion with residents and preceptors.

3.2.c Preceptors use the appropriate preceptor role (i.e., direct instruction, modeling, coaching, and facilitating) based on each resident’s progression through the learning experience.

Guidance
• 3.2.c The preceptor role may vary based on residents’ progression.
  o Direct instruction at level appropriate for residents (as opposed to students), only when needed.
  o Modeling of practice skills described in the educational objectives.
  o Coaching skills described in the educational objectives, providing regular, on-going feedback.
  o Facilitating by allowing resident to assume increasing levels of responsibility for performance of skills with indirect support of the preceptor as needed.
How it will be surveyed
- Review of learning experience descriptions.
- Discussion with residents, preceptors, and RPD.

3.3 Development Plan

3.3.a Each resident documents a self-assessment at the beginning of, or prior to, the start of the residency as part of the initial development plan.

Guidance
- 3.3 Residents’ development plans are high level summaries of resident’s performance and progress throughout the program, including progress towards achieving the completion requirements of the residency program. Development plans also support resident’s practice interests, career development, and resident wellness and resilience. Development plans include three components:
  - Resident documented self-reflection and self-evaluation: The self-reflection component includes, but is not limited to, documented reflection by the resident on career goals, practice interests, and wellness. The self-evaluation component includes self-evaluation on the resident’s skill level related to the program’s competency areas.
  - RPD documented assessment of the resident’s strengths and opportunities for improvement relative to the program’s competency areas, goals, and objectives; progress towards achievement of objectives for the residency (ACHR) and all other completion requirements of the program; and analysis of the effectiveness of the previous quarter’s changes.
  - RPD documented planned changes to the resident’s residency program for the upcoming quarter. (NOTE: An optional development plan template will be developed in PharmAcademic™ that can be used by both residents and RPDs.)

- 3.3.a Resident self-assessment includes both self-reflection and self-evaluation. Self-reflection is defined as thinking about one’s self, including one’s behavior, values, knowledge, and growth opportunities. Residents document self-reflection on career goals, areas of clinical interest, personal strengths and opportunities for improvement, and stress management strategies as part of the initial self-assessment. Self-evaluation is comparing one’s performance to a benchmark. Residents will compare their current skills to each competency area and identify specific areas of strength and specific areas that the resident feels are the highest opportunities for growth.

- 3.3.a Resident document their initial self-assessment on the ASHP REQUIRED FORM (Note: In development) in PharmAcademic™. Programs can require residents to complete a program-specific self-assessment in addition to the ASHP REQUIRED FORM.

How it will be surveyed
- 3.3.a: Review of ASHP REQUIRED FORMs.

3.3.b The RPD or designee develops, discusses, and documents with each resident an initial development plan, within 30 days from the start of the residency.

3.3.b.1 The initial development plan is based on the results of the resident’s initial self-assessment and the RPD’s assessment of resident’s knowledge and skills related to the program’s required educational objectives.
3.3.b.2 The RPD or designee documents adjustments to the program for the resident in the initial plan.

3.3.c The RPD or designee finalizes residents’ initial development plan in PharmAcademic™ within 30 days from the start of the residency.

**Guidance**

- 3.3.b The development plan may be documented on the same form as the resident’s self-assessment in PharmAcademic™.
- 3.3.b.2 Adjustments to the plan are based on resident’s strengths and opportunities for improvement relative the programs competency areas, practice interests, and career goals.
- 3.3.b.2 Documented advice to the resident is not an adjustment to the program. An adjustment is a change from the baseline program structure for a specific resident. Following are some examples of program adjustments: Adding an additional presentation and practice time with the preceptor for a resident who considers their presentation skills as a weakness; moving a critical care learning experience to the first quarter for a resident who is interested in pursuing a PGY2 in critical care; eliminating components of orientation for a resident who was a former pharmacy intern; adding hands-on sterile compounding training for one who has no prior experience.
- Finalizing the development plan includes sharing with preceptors through PharmAcademic™

**How it will be surveyed**

- Review of initial development plan in PharmAcademic™.
- Review of dates the initial development plan is finalized in PharmAcademic™.

3.3.d An update to the resident’s self-assessment and an update to the development plan are documented and finalized in PharmAcademic™ every 90 days from the start of the residency.

3.3.d.1 Prior to each development plan update, the resident will document an updated self-assessment that includes:

- 3.3.d.1.a An assessment of their progress on previously identified opportunities for improvement related to the competency areas.
- 3.3.d.1.b Changes in their strengths and opportunities for improvement related to the competency areas.
- 3.3.d.1.c Changes in their practice interests.
- 3.3.d.1.d Changes in their careers goals immediately post residency.
- 3.3.d.1.e Current assessment of their wellness.

3.3.d.2 The RPD or designee documents the following in each development plan update and discusses with resident:

- 3.3.d.2.a An assessment of progress on previously identified opportunities for improvement related to the competency areas.
3.3.d.2.b Changes in the strengths and opportunities for improvement related to the competency areas.

3.3.d.2.c Accuracy of the resident’s self-assessment on previous opportunities for improvement and changes in strengths and opportunities for improvement related to the competency areas.

3.3.d.2.d Objectives achieved for the residency (ACHR) since last plan update.

3.3.d.2.e Adjustments to the program for the resident.

3.3.e The RPD or designee documents updates to the resident’s progress towards meeting all other program completion requirements at the same time the development plan update is documented.

**Guidance**

- 3.3.d Update to the resident self-assessment and development plan are finalized and shared through PharmAcademic™.
- 3.3.d The due date is from the start of the residency, not the date of the last documented plan. Development plans not documented and shared within a month of the due date are considered to be late. For example, for programs where resident start date is July 1st, updates to the development plan are to be completed by the end of October, January, and April.
- 3.3.d.1.a and 3.3.d.1.b Commonly identified opportunities for improvement from residents can be tied to the program’s competency areas and may include time management, prioritization, clinical acumen, presentations, confidence, assertiveness, and evidence-based medicine knowledge.
- 3.3.d.2.d Adjustments to the plan are based on resident’s strengths and opportunities for improvement relative to the program’s competency areas, practice interests, and career goals.
- 3.3.e The update to the completion requirements can be included in the development plan or in a separate document. If in a separate document, the quarterly update to the completion requirements is documented on the same schedule as the update to the development plan.

**How it will be surveyed**

- 3.3.d Review of dates resident self-assessment and development plan updates are finalized in PharmAcademic™.
- 3.3.d.1 and 3.3.d.2 Review of resident self-assessment and development plan updates in PharmAcademic™.
- 3.3.e Review of completion requirements updates.

3.4 Evaluation of the Resident

3.4.a Formative assessment and feedback

3.4.a.1 Preceptors provide feedback to residents about how they are progressing and how they can improve.
3.4.a.1.a Feedback is documented for residents not progressing as expected.

3.4.a.2 Preceptors make appropriate adjustments to learning expectations based on residents’ progression.

**Guidance**
- 3.4.a.1 Ongoing verbal feedback to residents is frequent, specific, and constructive.
- 3.4.a.1 The frequency of ongoing feedback varies based on residents’ progress and time of the year.
- 3.4.a.1.a Residents who are not progressing according to expectations receive more frequent formative feedback. Specific recommendations for improvement and achievement of objectives are documented (e.g., feedback functionality in PharmAcademic™, written comments on draft document developed by resident).
- 3.4.a.2 Examples of adjustments in expectations include adjusting the number of patients assigned, expectations for projects and presentations, and expectations for resident check-in with the preceptor.

**How it will be surveyed**
- Discussion with residents and preceptors.
- Review of documented feedback

3.4.b Summative evaluation

3.4.b.1 Preceptors for the learning experience document a summative evaluation of the resident by the end of each learning experience.

3.4.b.1.a For learning experiences greater than 12 weeks, a summative evaluation is completed at evenly spaced intervals and by the end of the learning experience, with a maximum of 12 weeks between evaluations.

**Guidance**
- 3.4.b.1.a PharmAcademic will auto-schedule evaluations for learning experiences greater than 12 weeks based upon the duration and standard requirements.
- Examples of evaluation schedules for learning experiences greater than 12 weeks.
  - 16 week learning experience: An evaluation will be scheduled at 8 weeks and end of learning experience.
  - 36 week learning experience: Evaluations will be scheduled at 12 weeks, 24 weeks, and at end of learning experience.
  - 40 week learning experience: Evaluations will be scheduled every 70 days (i.e., at end of 10th, 20th, and 30th weeks and at the end of the learning experience).
  - 52 week learning experience: Evaluations will be scheduled every 91 days.

**How it will be surveyed**
- Review of PharmAcademic™ Evaluation Dashboards and Overall Evaluation Status Reports.
- For survey purposes, programs will not be in full compliance with timeliness if greater than ten percent of evaluations are completed more than seven days after the due date. Also, programs will not be in full compliance if any evaluations are completed greater than a month past due date.
3.4.b.2 The documented summative evaluation includes the extent of the resident’s progress toward achievement of assigned objectives based on a defined rating scale.

3.4.b.2.a The preceptor documents qualitative written comments specific to the evaluated objectives.

3.4.b.2.b The preceptor and resident discuss each summative evaluation.

**Guidance**
- 3.4.b.2 The program’s defined rating scale is documented in the program’s manual.
- 3.4.b.2.a Qualitative written comments:
  - Are specific and actionable.
  - Use criteria related to specific educational objectives.
  - Recognize residents’ skill development.
  - Focus on how residents’ may improve their performance.
- See examples on ASHP website *(Note: In development)*

**How it will be surveyed**
- Review of preceptors’ summative evaluations of residents in PharmAcademic™.

3.4.b.3 If more than one preceptor is assigned to a learning experience, all preceptors provide input into residents’ evaluations.

**Guidance**
- If multiple preceptors, one preceptor is identified as the primary preceptor.
- Programs determine if each preceptor documents input in PharmAcademic™ or if learning experience preceptors will provide verbal or written input to the primary preceptor for documentation of the evaluation in PharmAcademic™.
- The primary preceptor seeks consensus of preceptors to determine final ratings.

**How it will be surveyed**
- Review of summative evaluations.
- Discussion with preceptors and residents.

3.4.b.4 Residents document and discuss an evaluation of each preceptor by the end of the learning experience.

**Guidance**
- All preceptors with significant exposure to working with residents in a learning experience are to be listed as preceptors in PharmAcademic™ and evaluated by residents.

**How it will be surveyed**
- Review of residents’ evaluations of preceptors.
- Review of PharmAcademic™ Evaluation Dashboards and Overall Evaluation Status Reports.
- Discussion with preceptors and residents.
- For survey purposes, programs will not be in full compliance with timeliness if greater than ten percent of evaluations are completed more than seven days after the end of the learning experience or if any evaluations are completed greater than a month past the end of the learning experience.
### Guidance

- **3.4.b.5.a** PharmAcademic™ will auto-schedule evaluations for learning experiences greater than 12 weeks based upon the duration and standard requirements.

### How it will be surveyed

- **3.4.b.5 and 3.4.b.5.a** For survey purposes, programs will not be in compliance with timeliness if greater than ten percent of evaluations are completed more than seven days after the due date or if any evaluations are completed greater than a month past the due date.
- Review of residents’ evaluations of learning experiences.
- Review of PharmAcademic™ evaluation dashboards and Overall Evaluation Status Reports.
- Discussion with preceptors and residents.

### 3.5 Continuous Residency Program Improvement

- **3.5.a** The RPD, residency advisory committee, pharmacy leaders, preceptors, and residents engage in an on-going process of assessment of the residency program.

#### 3.5.a.1

- **3.5.a.1.a** Assessment of methods for recruitment, including recruitment of a diverse and inclusive applicant pool.
- **3.5.a.1.b** End-of-the-year input from residents who complete the program.
- **3.5.a.1.c** Input from residents’ evaluations of preceptors and learning experiences.
- **3.5.a.1.d** Input from preceptors related to continuous program improvement.
- **3.5.a.1.e** Documentation of program improvement opportunities and plans for changes to the program.

- **3.5.b** The RPD or designee implements program improvement activities in response to the results of the assessment of the residency program.

#### Guidance

- **3.5.a** Examples of ongoing program assessment may include ongoing discussion of program improvement opportunities at residency advisory committee or other meetings, discussion of applicant selection process outcomes, ongoing review of learning experiences, and review of residents’ evaluations of preceptors and learning experiences.
- **3.5.a.1** Assessment of methods for recruitment of a diverse and inclusive applicant pool may include:
- Review of the applicant pool to determine increased variety of applicants from:
  - different geographic locations around the country
  - a variety of colleges and schools of pharmacy, including HBCUs and those with higher percentages of underrepresented individuals in the profession of pharmacy [Note: HYPERLINK TO AACP DATA]
- Review of advertising and marketing of the residency program. Examples include:
  - attendance at residency showcases hosted by HBCUs or colleges/schools of pharmacy with a higher percentage of individuals underrepresented in the profession of pharmacy [Note: HYPERLINK TO AACP DATA]
  - inclusion of images in promotional materials and/or the program website, that reflect diversity of past residency classes and/or the department of pharmacy
- Review of screening tools and rubrics used in the selection and ranking process for elimination of bias

- 3.5.a.1.b Input includes how effectively the program structure facilitated achievement of the objectives.
- 3.5.a.1.d When all preceptors are not part of the residency advisory committee, RPD has a process to solicit input from all preceptors (e.g., a survey).

How it will be surveyed
- Review of:
  - Documentation of program improvement opportunities and plans for changes to the program.
  - Residency Advisory Meeting minutes, as applicable.
- Discussion with RPD and preceptors about the program’s continuous quality improvement efforts.

Standard 4: Requirements of the Residency Program Director and Preceptors

4.1 Each residency program must have a single residency program director (RPD) who serves as the organizationally authorized leader of the residency program.

Guidance
- When interim leadership for a residency program is required due to vacancy or leave of absence of the RPD, the director of pharmacy or administrative authority such as the residency advisory committee (RAC), may appoint a pharmacist to serve as Interim RPD.
  - The interim appointment is acceptable for a period of no longer than 120 days.
  - The organization is not required to notify ASHP, but must change the RPD in PharmAcademic™ to the Interim RPD for continued administration of the residency program.
  - By the end of the 120-day period, a new RPD must be appointed if the previous RPD is unable to resume RPD responsibilities.
  - Information for a change in RPD must be sent to the Accreditation Services Office (asd@ashp.org) at or before the completion of the 120-day interim appointment. Submitted information must include an updated Academic and Professional Record and an updated Curriculum Vitae.

How it will be surveyed
- Review of RPD’s Academic and Professional Record and PharmAcademic™. (Note: Academic and Professional Record under revision)
- Discussion with RPD
4.2 RPD Eligibility

4.2.a PGY1 RPDs are licensed pharmacists from the practice site or from the sponsoring organization who:

- Completed an ASHP-accredited PGY1 residency and a minimum of three years of relevant pharmacy practice experience; or

- Completed ASHP-accredited PGY1 and PGY2 residencies and a minimum of one year of relevant pharmacy practice experience; or

- Without completion of an ASHP-accredited residency, has a minimum of five years of relevant pharmacy practice experience.

4.2.b PGY2 RPDs are licensed pharmacists from the practice site or from the sponsoring organization who:

- Completed an ASHP-accredited PGY2 residency in the advanced practice area, and a minimum of three years of additional practice experience in the PGY2 advanced practice area, or

- Without completion of an ASHP-accredited PGY2 residency in the advanced practice area has a minimum of five years of experience in the PGY2 advanced practice area.

Guidance

- ASHP-accredited pharmacy residency programs includes residencies in candidate status.

4.2.a PGY1 RPD’s pharmacy practice experience is relevant to the practice setting in which the residency is conducted. For PGY1 Community-based Pharmacy, relevant practice settings are community and ambulatory care practice settings. For PGY1 Managed Care Pharmacy, relevant practice settings are health plan and pharmacy benefit manager practice settings or managed care experience that would be received from practicing in these settings.

4.2.b PGY2 RPD’s pharmacy practice experience is in the same advanced practice area in which the resident is being trained.

How it will be surveyed

- Review of RPD’s Academic and Professional Record

4.3 RPD Qualifications: RPDs serve as role models for pharmacy practice and professionalism as evidenced by:

4.3.a For PGY2 RPDs, maintaining BPS certification in the specialty when certification is offered in that specific advanced area of practice.

4.3.b Contribution to pharmacy practice. For PGY2 RPD’s, this must be demonstrated relative to the RPD’s PGY2 practice area.

4.3.c Ongoing participation in drug policy or other committees/workgroups of the organization or enterprise

4.3.d Ongoing professional engagement
4.3.e Role modeling professionalism

4.3.f For PGY2 RPDs, maintaining regular and on-going responsibilities in the advanced practice area where they serve as the RPD.

Guidance

- 4.3.a For PGY2 Internal Medicine residencies, RPD maintains Board Certified Pharmacotherapy Specialist (BCPS) certification.
- 4.3.a For new board certifications, relevant board certifications are obtained by January 1 following three offerings of the exam. RPD’s who serve as BPS council members for new specialty areas obtain board certification within three years after completion of council member term.
- 4.3b RPDs demonstrate contribution to practice by documenting at least one example from the following categories (Academic and Professional Record): Examples are from the last four years of practice.
  - Contribution to the development of clinical or operational policies/guidelines/protocols
  - Contribution to the creation/implementation of a new clinical or operational service
  - Contribution to an existing service improvement
  - In-services or presentations to pharmacy staff or other health professionals at organization. This can be a single inservice/presentation given at least annually, or at least 3 different inservices/presentations in the past 4 years.
  - Contribution to the maintenance and development of residency policies
- 4.3.c Appointments to drug policy and other committees of the organization or enterprise (e.g., practice setting, college of pharmacy, independent pharmacy) – does not include membership on Residency Advisory Committee (RAC) or other residency-related committees. (Academic and Professional Record).
- 4.3.d Role modeling ongoing professional engagement is demonstrated by documenting at least 3 types of ongoing professional engagement (Academic and Professional Record).
  - Examples are from the last four years of practice with the exception of formal recognition of professional excellence over a career, which is considered a lifetime achievement award.
  - Examples occurred after preceptor obtained pharmacist licensure and after completion of residency training. Completion of a teaching certificate program is the only exception, as it could be obtained during residency training.
  - Types of professional engagement include:
    - Formal recognition of professional excellence over a career (e.g., fellow status for a national organization or pharmacist of the year recognition at state or regional level).
    - Primary preceptor for pharmacy APPE students.
    - Classroom/lab teaching experiences for healthcare students.
    - Service (beyond membership) in national, state, and/or local professional associations.
    - Presentations or posters at local, regional, and/or national professional meetings.
    - Completion of a teaching certificate program.
    - Providing preceptor development to other preceptors at the site.
• Evaluator at state/regional residency conferences; poster evaluator at professional meetings; and/or evaluator at other local/regional/state/national meetings.
• Publications in peer-reviewed journals or chapters in textbooks.
• Formal reviewer of submitted grants or manuscripts.
• Participant in wellness programs, health fairs, health-related consumer education classes, and/or employee wellness/disease prevention programs.
• Community service related to professional practice.
• Professional consultation to other health care facilities or professional organizations (e.g., invited thought leader for an outside organization, mock surveyor, or practitioner surveyor).
• Awards or recognitions at the organization or higher level for patient care, quality, or teaching excellence.

4.3.e The program director models and creates an environment that promotes outstanding Professionalism (e.g., environment free from harassment and bullying). Adapted from ACGME Common Requirements

How it will be surveyed
• Review of:
  o RPD’s Academic and Professional Record
  o Preceptor roster
• Discussion with RPD

4.4 RPD Leadership Responsibilities

4.4.a The RPD establishes a residency advisory committee to guide residency program design, conduct, and resident oversight. The committee allows for input from program preceptors representing required learning experiences.

4.4.a.1 If an oversight committee is used to make global decisions for all programs at a site or within an organization, a program-level committee must also be in place to manage program-level decisions.

4.4.a.2 The program-level committee meets at least quarterly.

4.4.a.3 Oversight and program-level committees document their discussions and decisions.

4.4.a.4 For multiple practice-site programs, site coordinators are included in the program-level committee.

Guidance
• 4.4.a Residency Advisory Committee responsibilities include but are not limited to: program design and conduct, residency policy development, oversight of resident progress, ongoing program assessment including an annual program review, and development of preceptors’ teaching/precepting skills.
• The intent of 4.4.a is to ensure that program leadership and preceptors are engaged in design and oversight of individual residency programs. The residency advisory committee can be designed to fit the program as long as it is in compliance with 4.4.a and 4.4.a.1 through 4.4.a.4.

How it will be surveyed
• Review of meeting agendas and minutes
• Discussion with RPD and preceptors

4.4.b  Appointment and Reappointment of Residency Program Preceptors

4.4.b.1  RPDs document appointment and reappointment criteria that are consistent with the standard.

4.4.b.2  RPDs apply criteria for initial preceptor appointment.

4.4.b.3  RPDs apply criteria for reappointment which include an evaluation of preceptor skills.

4.4.b.4  Preceptor appointment and reappointment terms do not exceed 4 years.

4.4.b.5  Preceptor appointment and reappointment decisions are documented.

Guidance

• 4.4.b  Process for appointment and selection of preceptors is inclusive of all pharmacists within the organization.
• 4.4.b.1-4.4.b.5  RPD may delegate these responsibilities (e.g., residency program coordinator, oversight body for multiple programs, RAC subcommittee). While the RPD can delegate, the RPD is still ultimately accountable for the process.
• 4.4.b.1  In addition to being consistent with The Standard, criteria may also include organization-specific criteria (e.g., attendance at required number of preceptor meetings).
• 4.4.b.3  Evaluation of preceptor skills could include but is not limited to resident feedback, review of evaluations in PharmAcademic, review of documentation of criteria-based feedback on summative evaluations.
• 4.4.b.5  Examples of documentation may include RAC minutes, spreadsheet, letter of appointment/reappointment, tracking tool, etc.

How it will be surveyed

• Review of documented criteria for appointment and reappointment.
• Review of documented appointment decisions
• Discussion with RPD about the appointment/reappointment process.

4.4.c  The RPD conducts ongoing preceptor development and creates a schedule of activities for each residency year based on a documented assessment of preceptor skills.

Guidance

• Multiple programs within an organization may partner to create and utilize a single preceptor development plan. Each RPD is still ultimately accountable for the process.
• Needs assessment uses appropriate methods to evaluate preceptors’ skills (e.g., review of residents’ evaluations of preceptors, peer review, preceptors’ self-assessments, and/or performance reviews).
• Preceptor development activities must be focused around increasing knowledge and skills that can be applied to effectively precepting residents regardless of practice setting (e.g., methods for providing effective feedback, understanding and applying the residency accreditation standard, setting clear expectations, instilling professionalism and confidence, tips for precepting a successful resident research project) rather than solely activities centered around improving or increasing clinical knowledge (e.g., reviewing practice guidelines, completing continuing education on a clinical topic).
• Consider education to the preceptors on burnout syndrome, the risks, and mitigation strategies. Resources available on the ASHP website can be found here: https://www.ashp.org/wellbeing

How it will be surveyed
• Review of documentation of the program’s preceptor development plan
• Review of processes used for preceptor evaluation, skills assessment, and development.
• Discussion with preceptors and RPD

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

Guidance
• The terms used (e.g., residency program coordinator) and definition of roles are determined by, and can vary by, program. The term “coordinator” is an example.

4.5 Pharmacist Preceptors’ Eligibility

4.5.a PGY1 Preceptors must be licensed pharmacists who:
• Have completed an ASHP-accredited PGY1 residency followed by a minimum of one year of pharmacy practice experience in the area precepted; or,
• Have completed an ASHP-accredited PGY1 residency followed by an ASHP-accredited PGY2 residency and a minimum of six months of pharmacy practice experience in the area precepted; or,
• Without completion of an ASHP-accredited residency, have three or more years of pharmacy practice experience in the area precepted.

Guidance
• ASHP-accredited pharmacy residency programs includes residencies in candidate status.

How it will be surveyed:
• Review of preceptor roster
• Review of preceptors’ academic and professional record forms

4.5.b PGY2 Preceptors must be licensed pharmacists who:
• Have completed an ASHP-accredited PGY2 residency followed by a minimum one-year of pharmacy practice experience in the area precepted.
• Without completion of an ASHP PGY2 residency, have three or more years of pharmacy practice experience in the area precepted.

Guidance
• ASHP-accredited pharmacy residency programs includes residencies in candidate status.
• Preceptor’s pharmacy practice experience is in the same advanced practice area in which the resident is being trained.

How it will be surveyed:
4.6  Preceptors’ Qualifications: Preceptors must demonstrate the ability to precept residents’ learning experiences as evidenced by

4.6.a  Content knowledge/expertise in the area(s) of pharmacy practice precepted.

**Guidance**

- Preceptors demonstrate at least one example of the following related to the area of pharmacy practice precepted (Academic and Professional Record):
  - Any active BPS Certification(s) (type(s) and expiration date).
  - Post-graduate fellowship in the advanced practice area or advanced degrees related to practice area beyond entry level degree (e.g., MS, MBA, MHA, PhD).
  - Completion of Pharmacy Leadership Academy (DPLA)
  - Pharmacy-related certification in the area precepted recognized by Council on Credentialing in Pharmacy (CCP): **Note: This does not include Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), or Pediatric Advanced Life Support (PALS).**
  - For non-direct patient care areas, nationally-recognized certification in the area precepted. Examples: Certified Professional in Healthcare Information and Management Systems (CPHIMS) or Medical Writer Certified (MWC)
  - Certificate of completion in the area precepted (minimum 14.5 contact hours or equivalent college credit) from an ACPE-accredited certificate program or accredited college/university. Certificate of completion obtained or renewed in last four years.
  - Privileging granted by preceptor’s current organization that meets the following criteria:
    - Includes peer review as part of the re-credentialing procedure.
    - Only utilized for advanced practice. Privileging for areas considered to be part of the normal scope of practice for pharmacists such as therapeutic substitution protocols or pharmacokinetic protocols will not meet the criteria for 4.6.a.
    - If privileging exists for other allied health professionals at the organization, pharmacist privileging must follow the same process.
  - Subject matter expertise as demonstrated by:
    - Completion of PGY2 residency training in the area precepted PLUS at least 2 years of practice experience in the area precepted.
    - Completion of PGY1 residency training PLUS at least 4 years of practice experience in the area precepted.
    - PGY2 residency training NOT in the area precepted PLUS at least 4 years of practice experience in the area precepted.
    - At least 5 years of practice experience in the area precepted.

**How it will be surveyed**

- Review of preceptors’ academic and professional record forms
- Review of one copy of organization’s privileging policy, example application packet, and applicable collaborative practice agreements/protocols if privileging is used to demonstrate content knowledge/expertise in the area(s) of pharmacy practice

4.6.b  Contribution to the pharmacy practice in the area precepted.
Guidance

- Preceptors demonstrate contribution to pharmacy practice in the area precepted by documenting at least one example that meets the following criteria (Academic and Professional Record).
  
  Examples are from the last four years of practice and occurred after preceptor obtained pharmacist licensure and after completion of residency training, if applicable.

  - Contribution to the development of clinical or operational policies/guidelines/protocols or
  - Contribution to the creation/implementation of a new clinical or operational service or
  - Contribution to an existing service improvement or
  - Appointments to drug policy and other committees of the organization or enterprise (e.g., practice setting, college of pharmacy, independent pharmacy) – does not include membership on Residency Advisory Committee (RAC) or other residency-related committees.
  - In-services or presentations to pharmacy staff or other health professionals at organization. This can be a single inservice/presentation given at least annually, or at least 3 different inservices/presentations in the past 4 years.

How it will be surveyed

- Review of preceptors’ academic and professional record forms

4.6.c Role models ongoing professional engagement.

- 4.6.c Role modeling ongoing professional engagement is demonstrated by documenting at least 3 types of ongoing professional engagement (Academic and Professional Record).
  
  - Examples are from the last four years of practice with the exception of formal recognition of professional excellence over a career, which is considered a lifetime achievement award.
  
  - Examples occurred after preceptor obtained pharmacist licensure and after completion of residency training. Completion of a teaching certificate program is the only exception, as it could be obtained during residency training.
  
  - Types of professional engagement include:
    - Formal recognition of professional excellence over a career (e.g., fellow status for a national organization or pharmacist of the year recognition at state or regional level).
    - Primary preceptor for pharmacy APPE students.
    - Classroom/lab teaching experiences for healthcare students.
    - Service (beyond membership) in national, state, and/or local professional associations.
    - Presentations or posters at local, regional, and/or national professional meetings.
    - Completion of a teaching certificate program.
    - Providing preceptor development to other preceptors at the site.
    - Evaluator at state/regional residency conferences; poster evaluator at professional meetings; and/or evaluator at other local/regional/state/national meetings.
    - Publications in peer-reviewed journals or chapters in textbooks.
    - Formal reviewer of submitted grants or manuscripts.
    - Participant in wellness programs, health fairs, health-related consumer education classes, and/or employee wellness/disease prevention programs.
- Community service related to professional practice.
- Professional consultation to other health care facilities or professional organizations (e.g., invited thought leader for an outside organization, mock surveyor, or practitioner surveyor).
- Awards or recognitions at the organization or higher level for patient care, quality, or teaching excellence.

**How it will be surveyed:**
- Review of preceptors’ academic and professional record forms.

4.6.d Preceptors who do not meet criteria for 4.6.a, 4.6.b, and/or 4.6.c have a documented individualized preceptor development plan to achieve qualifications within two years.

**Guidance**
- The plan is documented and provides opportunities for preceptors to meet preceptor qualifications within two years. The plan may be a component of an organizational performance review process.

**How it will be surveyed**
- Review of Academic and Professional Record
- Review of documented preceptor development plans.
- Discussion with preceptors and RPD.

4.7 Preceptors maintain an active practice or on-going responsibilities for the area in which they serve as preceptors.

4.7.a When precepting residents in their practice area, preceptors are present to guide resident learning.

**Guidance**
- Preceptor may be part-time and/or at a remote location but must be actively engaged
- If more than one preceptor is involved in the learning experience, the preceptor designated as the primary preceptor is present for approximately 50% (or more) of the learning experience (may not be applicable for orientation or staffing learning experiences).
- All preceptors engaged in the training of residents during a learning experience (i.e., team-precepted experiences) should be designated as preceptors for the experience (may not be applicable for orientation or staffing learning experiences).

**How it will be surveyed**
- Review of preceptor roster
- Review of residents’ evaluations of preceptors and learning experiences.
- Discussion with preceptors and residents

4.8 Non-Pharmacist Preceptors: When non-pharmacists (e.g., physicians, physician assistants, certified advanced practice providers) are utilized as preceptors.

4.8.a Direct patient care learning experiences are scheduled in the second half of the residency year after the RPD and preceptors agree that residents are ready for independent practice.

4.8.a.1 Readiness for independent practice is documented in the resident’s development plan.
4.8.b The RPD, designee, or other pharmacist preceptors work closely with the non-pharmacist preceptor to select the educational objectives and activities for the learning experience.

4.8.c The learning experience description includes the name of the non-pharmacist preceptor and documents the learning experience is a non-pharmacist precepted learning experience.

4.8.d At the end of the learning experience, input from the non-pharmacist preceptor is reflected in the documented criteria-based summative evaluation of the resident’s progress toward achievement of the educational objectives assigned to the learning experience.

**Guidance**

- Utilization of non-pharmacist preceptors may occur when a qualified pharmacist preceptor does not maintain an active practice in the area, but the experience adds value to residents’ professional development.
- 4.8.a Learning experiences where the resident is acquiring skills and abilities best taught by other health care professionals are exempted from 4.8.a (e.g., physical assessment and triage for PGY1 residents in community pharmacies or microbiology lab for PGY2 infectious diseases pharmacy residents).
- 4.8.a The requirement for readiness for independent practice also does not apply to non-direct patient care learning experiences (e.g., informatics, management, finance learning experiences).
- 4.8.b A qualified pharmacist preceptor oversees any learning experiences provided by a non-pharmacist preceptor and serves as a resource to both the non-pharmacist preceptor and resident.
- 4.8.b Educational objectives and corresponding activities selected for learning experiences precepted by non-pharmacist preceptors are appropriate for a non-pharmacist to teach and evaluate.
- 4.8.c Non-pharmacist preceptors are documented in the learning experience description and the description reflects the learning experience is precepted by a non-pharmacist preceptor.
- 4.8.d The summative evaluation is completed in PharmAcademic™ by either the non-pharmacist preceptor or by a pharmacist preceptor working with the non-pharmacist preceptor. If it is completed by a pharmacist preceptor, the pharmacist preceptor is listed on the Learning Experience Description, and the evaluation reflects input from the non-pharmacist preceptor.
- Non-pharmacist preceptors are not required to meet preceptor requirements or complete an Academic and Professional Record form.

**How it will be surveyed**

- Review of learning experience descriptions precepted by non-pharmacist preceptors
- Review of residents’ schedules
- Review of residents’ development plans
- Interview of residents and non-pharmacist preceptors
Standard 5: Pharmacy Services

Note: Pharmacy Services will be surveyed through review of pre-survey materials, discussion with pharmacy leaders and other stakeholders, and tour of the practice site.

5.1 Pharmacy Leadership

5.1.a Pharmacy Scope and Services

5.1.a.1 The scope of pharmacy services is documented.

5.1.a.2 Pharmacy has a well-defined, documented organizational structure in which the pharmacist leader provides oversight and supervision of all pharmacy personnel.

5.1.a.3 Pharmacy leaders have a documented plan that includes goals based on assessment of current and future pharmacy needs. Plan addresses:

   5.1.a.3.a space, facilities, information technology, and automation.

   5.1.a.3.b pharmacy services, and associated personnel complement, to provide the level of care required by all patients.

5.1.a.4 Pharmacy leaders hold decision-making roles and collaborate with other healthcare professionals in the planning and management of medication-use systems at the organizational level.

5.1.a.5 Pharmacy leaders ensure pharmacy services are of the scope, quality, and consistency to provide the level of care required by all patients.

5.1.a.6 Pharmacy leaders ensure the appropriate use of personnel.

5.1.a.7 Pharmacy leaders ensure that pharmacists provide patient-centered care plans and independently manage medication therapy.

5.1.a.8 Pharmacy services are integrated across the patient care continuum within the organization.

Guidance

- 5.1.a.1 Scope of services includes hours of operation and a description of distributive/operational and clinical services provided by the pharmacy.
- 5.1.a.2 Reporting structure may be indirect provided that pharmacy leadership is collaboratively involved in the planning of medication-related initiatives.
- 5.1.a.3
  - Documented plan is a pharmacy strategic plan or a pharmacy assessment and planning document.
    - Cascading goals from the organization can be reflected in the plan, but must be specific to pharmacy. (Do not provide organization’s strategic plan in lieu of the pharmacy strategic plan.)
For organizations with a corporate or system-wide pharmacy plan, the plan must be specific to the site in which the program is conducted.

- Pharmacy plan includes:
  - Planning for expansion of services and personnel as applicable.
  - Timelines for implementation.
  - Assignment of responsible parties for implementation.
  - Tracking of progress toward achievement of goals of the plan.

- Pharmacy plan is communicated to all departmental staff and reported out to appropriate organizational leaders. NEW

5.1.a.4 Pharmacy leaders:
- Participate in the planning of patient care services (e.g., if planning a new clinical service, pharmacy is involved from the beginning).
- Collaborate with other healthcare professionals to ensure safe medication-use systems (e.g., pharmacy is involved in reviewing overrides and controlling the drug library for smart pump use).
- Ensure pharmacy is engaged in decision-making on corporate/system-wide, organization-level, and local committees that oversee medication safety and optimal drug therapy (e.g., Pharmacy and Therapeutics, Quality, Medication Safety, Information Technology, Investigational Review Board).

5.1.a.5
- Pharmacy services at the practice site extend to all patients for which medications are prescribed, dispensed, administered, and monitored.
- The scope, quality, and consistency of services provided aligns with best practices.

5.1.a.6 All pharmacy personnel practice at the maximum level that their state or jurisdiction allows. Examples of a high level of practice for technicians include:
  - Tech-check-tech
  - Immunizations
  - Medication histories

5.1.a.7 All sites use pharmacist-managed protocols and/or collaborative practice agreements and/or statewide protocols.
- Pharmacist-managed protocols and collaborative practice agreements include any practice where pharmacists are independently managing medication therapy (i.e., pharmacists are not required to contact the prescriber to initiate, modify, and/or discontinue therapy in individual patients).
- State-wide protocols may include hormonal contraception, HIV prep-pack, and TB screening.

NOTE: For states that do not allow pharmacists to practice under collaborative practice agreements, pharmacy leaders within the organization should be involved in pharmacy advocacy within the state.

5.1.a.8 For pharmacies that are part of an organization or health-system, there is coordination across all areas where pharmacy services are provided throughout the organization (e.g., acute care, ambulatory care, outpatient pharmacy, home health, infusion centers, population health).

5.1.b External evaluation: Practice sites are accredited by external accrediting organizations appropriate to the practice environment.

Guidance
• If external accreditation is not feasible, practice sites conduct self-assessments of medication-use practices against established and recognized accreditation standards or best practice guidelines relevant to the practice environment.

• Examples of established/recognized accreditation standards or best practice guidelines include but are not limited to ACHC, URAC, NCQA, TJC, DNV.

5.1.c Personnel: Pharmacy leaders oversee the hiring, development, and support of pharmacy staff by:

- 5.1.c.1 Ensuring hiring of pharmacy personnel includes methods to facilitate recruitment of a diverse and inclusive pharmacy workforce. NEW
- 5.1.c.2 Providing resources for on-going professional development for pharmacists and pharmacy technicians.
- 5.1.c.3 Ensuring the competence of pharmacists is validated through an ongoing, formalized process.
- 5.1.c.4 Ensuring the competence of pharmacy technicians performing specialized functions is validated through an ongoing, formalized process. NEW
- 5.1.c.5 Providing resources for assessing and supporting staff resilience and well-being. NEW
- 5.1.c.6 Providing program administration time to the residency program director (RPD) to support residency training. NEW
- 5.1.c.7 Providing support for the ongoing improvement of the residency program(s). NEW

Guidance

- 5.1.c.1 Recruitment identifies and engages individuals underrepresented in the profession of pharmacy. In addition, if the patient population served by the organization is an underserved population, the pharmacist executive should include a workforce whose background, perspectives, and/or experiences reflect the diverse patients for whom care is provided. [See Appendix for definition of terms: diverse, inclusive, underrepresented]
  - Recruitment methods and interview procedures employ measures to reduce implicit bias (i.e., objective assessment based on applicants’ qualifications and previous experience related to the recruited position).

ASHP Policy Positions (1705)

Source: Council on Education and Workforce Development

As the U.S. becomes more heterogeneous, the pharmacy workforce should reflect and respond to this increasingly diverse patient base. An inclusive pharmacy workforce is best able to positively impact the health and wellness of patients for whom pharmacists provide care. According to the Institute of Medicine, increasing diversity among healthcare providers is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better educational experiences for health professions students.1,2 Diversity in the pharmacy workforce includes, but is not limited to, the categories of sexual orientation and gender expression, age, national origin, socioeconomic origin, ethnicity,
culture, gender, race, religion, and persons with disabilities. A diverse pharmacy workforce will provide the best care for all patients.


- 5.1.c.2 Examples of resources may include: career ladders; conference time; support for involvement in local, state, or national pharmacy organizations; and reimbursement for professional meetings, professional certifications, and continuing education.
- 5.1.c.3 Process includes:
  o both initial and continuing competence
  o assessment of individual pharmacist performance in both the management of patients’ drug therapy and in required operational activities/functions (e.g., peer-review process, credentialing and/or privileging, administration of clinical and operational competencies)
- 5.1.c.4 The process includes both initial and continuing competence. Specialized technician functions may include tech-check-tech, medication history, hazardous sterile and non-sterile preparation, and immunizations.
- 5.1.c.5 Pharmacy leaders may utilize organizational resources and initiatives; resources and initiatives do not have to be pharmacy-specific. All personnel (including residents) have access to resources. Examples may include brochures, webinars, employee assistance programs, trainings, fitness activities, meditation activities, vendor partnerships and seminars.
- 5.1.c.6 The RPD is provided a minimum of four (4) hours per week of residency program administration time on average, over the course of each residency year. Additional time may be required based upon factors such as program size, time of the year, and availability of additional support personnel.
- 5.1.c.7 Leaders ensure that residency program directors have resources needed to implement the opportunities identified through the program’s continuous improvement process (see Standard 3).

5.1.d Infrastructure: The pharmacy department has sufficient resources to support its work including:

- 5.1.d.1 Access to appropriate resources necessary to provide the scope of services.
- 5.1.d.2 Space to facilitate safe and efficient medication-use processes. [N/A for MANAGED CARE]
- 5.1.d.3 Space to provide confidential patient care services and discussions with patients/family members/caregivers and members of the healthcare team.

Guidance:
- 5.1.d.1 Pharmacy employees have access to resources needed to perform daily tasks, including the electronic health record/pharmacy database, patient assessment and clinical decision support tools, drug information resources, equipment, and technology.
- 5.1.d.2 Space provides an area large enough to promote safe and efficient work, including preparation, verification, and dispensing of medications, as well as adequate storage for all medications within the pharmacy. Adheres to USP 795, USP 797, and USP 800 standards.
5.1.d.3 The pharmacy is designed to include appropriate space to preserve confidentiality, whether care is provided in person or virtually. Confidential patient care services may include medication administration, patient assessments, counseling, and discussions about patient treatment plans.

5.2 Medication Use Systems: Pharmacy governs safe medication-use systems.

5.2.a Pharmacy maintains oversight and authority for all areas where medications are stored, prepared, dispensed, administered, and monitored.

5.2.b Medication-use policies reflect current best practices and national guidelines and include but are not limited to:

5.2.b.1 Management of secure storage for all medications. [N/A for MANAGED CARE]

5.2.b.2 Identification, storage and labeling of high risk/high alert medications. [N/A for MANAGED CARE]

5.2.b.3 Management of medications that have specific regulatory, compliance or reporting requirements. NEW

5.2.b.4 Management of medications in automated storage and dispensing systems. [N/A for MANAGED CARE]

5.2.b.5 Management of hazardous medications. [N/A for MANAGED CARE]

5.2.b.6 Procedures to ensure that all medications are dispensed in a ready-to-administer dose. [N/A for MANAGED CARE]

5.2.c Medication-use policies are followed.

5.2.d Medication-use policies are routinely reviewed, updated, and available to all staff.

Guidance:

5.2.a

- Encompasses areas both internal and external to the pharmacy such as pharmacy satellites, medication rooms on nursing units, infusion centers, the emergency department, ambulatory care clinics, and procedural areas; also included are processes for code carts, emergency kits, and any outsourced medications.
- Pharmacy leads efforts to optimize safe medication-use systems when collaborating with other disciplines.

5.2.b Policies include the following as applicable to the practice environment: (Note: best practice reference sources to be added)

- 5.2.b.1 Storage
  - Policies address the security of medications in all storage areas (e.g., medication rooms, satellites, clinics, ambulatory care areas, procedural areas)
- 5.2.b.2 High risk/High alert
  - A defined list of high risk/high alert medications
  - For pharmacies that prepare pediatric medications:
• The process for oral and injectable extemporaneously prepared products is documented and includes appropriate safety measures. (e.g., if batching of pediatric doses is combined with adult batching, they are prepared at the end of the run; in different hoods or preparation areas; etc.)

  5.2.b.3 Special requirements
  ▪ Investigational drugs
  ▪ Controlled substances
  ▪ Medications with Risk Evaluation and Mitigation Strategies requirements (REMS)
  ▪ Limited distribution drugs (LDD) and/or medications that have specific regulatory, compliance or reporting requirements

  5.2.b.4 Automated dispensing cabinets (ADCs)
  ▪ Systems to ensure patient safety when medications are dispensed without prospective review:
    ▪ Criteria and approval process for determining which medications may be overridden or auto-verified is documented; includes frequency of review. NEW [N/A for Community, Managed Care]
    ▪ Process and frequency of pharmacy review of medication override reports is documented. NEW [N/A for Community, Managed Care]
    ▪ Process for resolving discrepancies between actual inventory vs. the stated inventory is documented. [N/A for Managed Care]

  5.2.b.5 Hazardous medications
  ▪ A defined list of hazardous medications
  ▪ Procedures to ensure medications are received, stored, prepared, transported, administered, and wasted/disposed of in a manner to promote safe work practices and minimize occupational exposure.

  5.2.b.6 Ready-to-administer form
  ▪ Process for identifying and formally evaluating medications that are not provided in a ready-to-administer dose to ensure appropriate safety measures are established (e.g., tablet splitting; oral liquid doses, IV admixtures).
  ▪ Prescriptions dispensed for self-administration by outpatients are prepared in a form that minimizes risk of error and the need for manipulation by patients/caregivers.
  ▪ Assuring patient has needed accessories with certain products like insulin pen needles when a pen is prescribed, correct glucose meter strips for machine purchased, provision of oral syringes and tablet splitters.
  ▪ Exceptions include but are not limited to multi-dose vials (e.g., naloxone and insulin), injections that need to be reconstituted at time of use due to stability (e.g., glucagon).

  5.2.c All policies in 5.2.b are followed by personnel impacted by the scope of the policy.

  5.2.d Policies are reviewed routinely and at an interval established by pharmacy, but at least every three (3) years.

5.2.e. The use of information technology and automation is consistent with established best practices to optimize medication safety and efficiency in the medication-use process.

  5.2.e.1 Medication-use technologies support sharing of patient data across information systems and patient care settings.

  5.2.e.2 Pharmacy has a leadership role in efforts to evaluate and ensure compliance with established best practices/benchmarks.
5.2.f Pharmacy has a leadership role in the medication safety program, including the routine collection, analysis, and implementation of action plans related to medication safety events.

5.2.g Pharmacy is involved in the development, review, approval, dissemination, and implementation of evidence-based treatment protocols and medication-use guidelines/initiatives.

5.2.g.1 Pharmacy assesses the safety, effectiveness, and outcomes of treatment protocols, medication-use guidelines, and/or other systematic approaches to disease management.

5.2.g.2 Pharmacy implements new or revised policies or procedures based on results to improve the safe and effective use of medications.

5.2.h Pharmacy develops and manages an evidence-based formulary. [N/A COMMUNITY]

Guidance:

- 5.2.e Technology and automation is used to optimize medication safety and efficiency in the medication-use process (e.g., automated dispensing cabinets (ADCs) are profiled; bar code technology used in stocking/removing/restocking; pharmacy management of libraries for smart infusion pumps).
  o Measures are in place to ensure safe medication use if technology isn’t optimized to best practice level (e.g., Criteria for medications that may not be overridden such as high risk/high alert, medications requiring weight-based dosing, etc.).
- 5.2.e.1
  o The number of different information system and technology platforms are streamlined in an effort to avoid multiple sources of patient information and minimize potential errors in the documentation and communication of patient information during care transitions.
  o Technologies support connectivity and/or interoperability of information systems
  o Examples of connectivity and/or interoperability of information systems includes, but is not limited to:
    ▪ smart pumps interfaced with electronic health record
    ▪ computerized physician order-entry (CPOE) throughout the organization,
    ▪ Managed care, ambulatory care, and community settings - examples include:
      ▪ information systems that can generation identification of patients that need therapy optimized
      ▪ formulary integration across systems
      ▪ online prior-authorizations
      ▪ medication synchronization
      ▪ targeted clinical interventions
- 5.2.e.2
  o May be performed in collaboration with other disciplines.
  o Examples include, but are not limited to review of:
    ▪ bar-code medication administration compliance rates (BCMA)
    ▪ automated dispensing cabinet (ADC) override rates
    ▪ smart pump compliance rates
    ▪ misfill rates
    ▪ drug utilization review (DUR) reports
    ▪ incomplete product final verification reports
• 5.2.f Medication Safety
  o Should be performed in collaboration with other disciplines.
  o Processes are established and information systems developed for reporting, analyzing, and monitoring of events.
  o Action plans and process changes are implemented based on the analysis of the data collected and analyzed.
  o Reporting rates are reviewed and aligned with department/organization size
  o Results are reported out to appropriate department and organizational leaders/oversight committee. NEW

• 5.2.g Should be performed in collaboration with other disciplines.

• 5.2.g.1 Continuous quality improvement (CQI) process should include assessment of effectiveness, outcomes and use of treatment protocols, medication-use guidelines, and/or other systematic approaches to disease management.
  o Examples of effectiveness may include but are not limited to:
    ▪ Routine performance of medication-use evaluations to assess the use of, and effectiveness of protocols.
  o Examples of outcomes may include but are not limited to:
    ▪ Percent of patients at established therapeutic goals for A1c, blood pressure, lipid profile.
    ▪ Antimicrobial stewardship program reporting metrics.
    ▪ Proportion of days covered (PDC).
  o Examples of use may include but are not limited to:
    ▪ Capture rate of eligible patients
    ▪ Consistent use of protocols, etc. by all pharmacists

• 5.2.g.2 Appropriate actions based on results are implemented. (e.g. repeat MUE in 1 year)

• 5.2.h The process for formulary management accounts for all care areas where medications are administered to patients (e.g., clinics, infusion centers, inpatient).

5.3 Patient-Centered Care

5.3.a Patient care delivery is comprehensive, collaborative, and accessible.

5.3.a.1 Pharmacists provide comprehensive care that encompasses all medication-related issues in patients.

5.3.a.2 Pharmacists utilize clinical decision support tools to identify and prioritize patients requiring optimization of their medication therapy.

5.3.a.3 Pharmacists utilize evidence-based treatment protocols, medication use guidelines, and/or other systematic approaches to disease management.

5.3.a.4 Pharmacists collaborate with other health professionals to provide team-based care.
5.3.a.5 Pharmacists collaborate with the patient, family, and caregivers to manage patient care medication-related needs and education.

5.3.a.6 Pharmacists and pharmacy technicians lead medication-related transitions of care activities.

5.3.a.7 Pharmacists provide disease prevention and health and wellness services.

5.3.a.8 Pharmacy services are available during the time patient care services are provided in the practice setting. NEW

Guidance

• 5.3.a.1
  o Comprehensive care includes identification of all medication-related problems including appropriate treatment; appropriate indication, dose and regimen; effectiveness; safety; and, adherence.
    ▪ Encompasses both frequency of review and comprehensiveness
  o [COMMUNITY] Provision of medication management services, includes but is not limited to:
    ▪ Comprehensive medication management, including completion of comprehensive medication reviews (CMRs), profile review, medication reconciliation
    ▪ Targeted medication management
      • statins for patients with diabetes
      • adherence to antipsychotics and antidepressants
      • use of controller medications in asthma
      • annual TSH measurements for patients on thyroid replacement medications
    ▪ Medication synchronization
    ▪ Medication reconciliation
    ▪ Medication adherence
• 5.3.a.2 Pharmacy has processes in place to provide population health services.
  o In a hospital or ambulatory care setting, clinical decision support (CDS) includes clinical monitoring tools built into the electronic health record (EHR) to determine prioritization of patients, use of targeted patient lists to determine the type of intervention needed, etc.
  o CDS may include:
    ▪ Medication Therapy Management (MTM) programs – including targeted medication reviews (TMR) and comprehensive medication review (CMR) identification
    ▪ Artificial intelligence and machine learning tools
    ▪ Pharmacoadherence tools
    ▪ Tools to identify needed care or gaps in services for patients
    ▪ Tools to access formulary guidelines
• 5.3.a.4:
  o Examples include:
    ▪ Daily or Discharge rounds
    ▪ Via telecommunication for targeted interventions in the community pharmacy setting
    ▪ Recognizing when a patient needs a higher level of care/triaging
    ▪ Interaction and collaboration with other healthcare professionals also occurs during the provision of educational programs about medications, medication therapy, health, and other related matters to other healthcare providers.
• 5.3.a.5
### Pharmacists:
- Provide educational programs about medications, medication therapy, health, and other related matters to patients, family, and caregivers.
- Update medication list and a medication action plan consistent with comprehensive medication therapy management (MTM). [COMMUNITY and MANAGED CARE]
- Provide patient counseling and education services on medication initiation; medication changes; for high-risk medications and high-risk patients; and, assist patients with self-care decisions (e.g., OTC). Perform financial assessments and/or refer or facilitate enrollment of patients in Patient Assistance Programs (PAP). [COMMUNITY ONLY]
- Provide written and oral consultations regarding medication management therapy. [MANAGED CARE ONLY]
- Care is provided in a way that is coordinated and convenient to the patient and caregivers (e.g., virtual visits, telehealth services, patient-provider messaging). NEW

### Pharmacists and pharmacy technicians:
- Perform medication histories and update medication lists through all care transitions; take appropriate actions and communicate with appropriate members of the healthcare team.
- Provide patient education.

### Health and wellness services can include but are not limited to:
- Immunizations
- Health screenings
- Wellness visits (falls risk, depression risk, etc.)
- Travel medicine
- Wellness programs including smoking cessation, weight loss, pain management, etc.
- Health fairs
- Medication take-back
- Disease prevention patient education classes
- Naloxone education

### When 24/7 services aren’t provided, pharmacies:
- Justify the absence of pharmacy services (e.g., community pharmacy with 9 am – 10 pm hours).
- Provide access to services remotely (e.g., contracted pharmacy services for prospective order verification and consultative services).
- Security measures are in place for access to medications during the hours that the pharmacy is closed (e.g., use of ADCs).
- Access to the physical pharmacy is restricted

### Care provided is safe, effective, and individualized to the patient.

#### Pharmacists prospectively design patient-centered care plans.

#### Pharmacists recommend and implement patient-centered care plans.

#### Pharmacists monitor and evaluate the effectiveness of the patient-centered care plan and modify the plan as needed.

#### Pharmacists document patient care recommendations, treatment plans, and
other services in the patient’s permanent medical record according to practice setting.

**Guidance**

NOTE: Provision of care to the individual patient follows the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists’ Patient Care Process.

- 5.3.b.1 As part of the design of safe and effective individualized patient-centered care plans, pharmacists consider the following information as available and appropriate to the practice setting:
  - collect relevant subjective and objective information
  - analyze and assess information based on
    - complete and current medication lists and medication-use history including prescription and nonprescription medications, herbal products, and other dietary supplements
    - relevant health data including medical history, health and wellness information, biometric test results, physical assessment findings, pharmacogenomics/pharmacogenetics information
    - patient lifestyle habits, preferences and beliefs, health and functional goals, and socioeconomic factors that affect access to medication(s) and other aspects of care
  - incorporate cultural competence and social determinants of health into development of the care plan and communication with patients/families/caregivers
  - address and resolve potential barriers (e.g., literacy, access, language needs)
  - perform physical assessments, point of care testing, and/or order laboratory tests [AMBULATORY CARE, COMMUNITY]

- 5.3.b.2 As part of the implementation of patient-centered care plans, pharmacists:
  - initiate, modify, discontinue, and/or administer medication therapy as authorized and in accordance with the scope of their practice as defined by state laws, collaborative practice agreements, protocols, and/or practice site policies.
  - resolve medication-related problems

- 5.3.b.3 As part of monitoring and evaluation of the effectiveness of the patient-care plan, pharmacists:
  - ensure appropriate follow-up and reassessment of the patient-care plan for modifications and adjustments to therapy
  - assess each medication for appropriateness, effectiveness, safety, and patient adherence

- 5.3.b.4 Clinical recommendations made by a pharmacist on behalf of the patient, as well as actions taken in accordance with these recommendations, should be documented in a permanent manner that makes the information available to all the healthcare professionals caring for the patient.
Glossary of Terms and Acronyms

Accreditation Council for Pharmacy Education (ACPE): ACPE is recognized by the United States (US) Department of Education as the national agency for accreditation of professional degree programs in pharmacy.

Academy of Managed Care Pharmacy (AMCP): The Academy of Managed Care Pharmacy is the national professional society dedicated to the concept and practice of pharmaceutical care in managed health care environments. Accreditation is granted by ASHP in partnership with AMCP under the Required Competency Areas, Goals, and Objectives for PGY1 Managed Care Pharmacy Residencies.

Accreditation Commission for Health Care (ACHC): is a non-profit accreditation organization that accredits many different types of healthcare organizations in the United States.

American Pharmacists Association (APhA): was the first-established professional society of pharmacists in the United States. The association consists of more than 62,000 practicing pharmacists, pharmaceutical scientists, student pharmacists, pharmacy technicians, and others interested in the profession. Accreditation is granted by ASHP in partnership with APhA under the Required Competency Areas, Goals, and Objectives for PGY1 Community-Based Pharmacy Residencies.

ASHP Residency Matching Program (Match): The ASHP Resident Matching Program provides an orderly process to help applicants obtain positions in pharmacy residency programs of their choice, and to help programs obtain applicants of their choice. It is administered by the National Matching Services, Inc. (NMS). See the NMS web site (https://natmatch.com/ashprmp/) for Match rules for both programs and applicants.

Board of Pharmacy Specialties (BPS): BPS is a post-licensure certification agency whose mission is to improve patient care by promoting the recognition and value of specialized training, knowledge, and skills in pharmacy and specialty board certification of pharmacists.

Comprehensive Medication Review (CMR): is a comprehensive assessment of a patients’ medications, including medication history and medication adherence of patients, obtained through review of the patient’s medication profile and patient interview.

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

Deliverables: Documents developed by residents that are related to educational objectives. Deliverables differ for each type of residency program but examples common to most/all residency programs include presentations; project manuscript; project presentation; examples of written communication to disseminate knowledge such as newsletters or written drug information; and examples of treatments protocols, guidelines, or drug monographs developed or revised by the resident.

Department of Defense (DOD): The DOD includes the Department of the Army, Department of the Navy, and Department of the Air Force.

Designee: An individual designated by the residency program director to perform duties as allowed by The Standard. A designee cannot be a resident in the residency program.
Det Norske Veritas (DNV) is a global independent organization dedicated to safeguarding life, property, and management. DNV Healthcare is a branch of DNV that accredits hospitals and other healthcare organizations.

Early Commitment Process/Early Commit: Process by which a PGY1 can apply for and be accepted to a PGY2 program in the same organization prior to the Match and in accordance with ASHP Match rules.

Foreign Pharmacy Graduate Examination Committee (FPGEC) Certification: Certification requirement for graduates of pharmacy schools not located in the United States (U.S.). Certification ensures that a foreign pharmacist’s education meets acceptable requirements as compared to education that U.S.-educated pharmacists are expected to have before they practice as licensed pharmacists. All applicants in the Match who graduated from pharmacy schools outside the U.S. must provide this certification or documentation of pharmacist licensure in the U.S. to register for the Match. This certification is conferred by the National Association of Boards of Pharmacy (NABP) and is required by all 50 states in the U.S., the District of Columbia, Guam, and Puerto Rico before applying for a license from a state board of pharmacy though some states exempt graduates from Canadian pharmacy schools from this requirement. Once FPGEC certification is obtained, each state has different requirements as part of the state’s licensure application process. To apply for FPGEC certification, applicants must currently be licensed and/or registered for unrestricted practice of pharmacy in a foreign country or jurisdiction. If the applicant’s pharmacy degree was issued after January 1, 2008, the applicant must have completed a minimum five-year pharmacy curriculum at the time of graduation. To obtain FPGEC certification, applicants who meet the eligibility requirements must achieve the minimal acceptable score for the Test of English as a Foreign Language and the Foreign Pharmacy Graduate Equivalency Examination (FPGEE).

Historically Black Colleges and Universities (HBCUs): HBCUs date back to the 19th century. Before the Civil Rights movement, HBCUs offered Black Americans one of their only routes to a college degree. Currently, there are approximately 100 HBCUs in the United States.

Indian Health Service (IHS): The Indian Health Service is an agency within the Department of Health and Human Services responsible for providing federal health services to American Indians and Alaska Natives. The IHS provides a comprehensive health service delivery system for approximately 2.6 million American Indians and Native Alaskans who belong to 574 federally recognized tribes in 37 states.

International Program: Residency program located outside of the United States and United States territories. Standards will apply to all residency programs, regardless of location, unless differentiated by The Standard.

Match Phase I: Phase I is the initial phase of the Match process. All applicants and programs submit their Rank Order Lists by the Rank Order List deadline for Phase I of the Match. The matching algorithm will be processed using those Rank Order Lists to place applicants into positions. The results of Phase I of the Match will then be distributed to applicants and programs.

Match Phase II: Programs with unfilled positions in Phase I of the Match will offer those positions to unmatched applicants in Phase II of the Match. New programs or positions that receive funding after Phase I of the Match may also be added into Phase II of the Match, and applicants who did not participate in Phase I of the Match may participate in Phase II. All applicants seeking positions after Phase I and all programs with available positions after Phase I submit their Rank Order Lists by the Rank Order List deadline for Phase II of the Match. A second match will be carried out using those Rank Order Lists, and the results of Phase II of the Match will then be distributed.
**Medication Use System**: Describes the complex process in which a medication reaches the patient and includes prescribing, order processing, dispensing, administration, and patient monitoring.

**National Association of Boards of Pharmacy (NABP)**: NABP is an independent, international, and impartial association that assists its member boards and jurisdictions for the purpose of protecting the public health. The National Association of Boards of Pharmacy (NABP) responsibilities include ensuring the public’s health and safety through its pharmacist license transfer and pharmacist competence assessment programs.

**National Matching Services, Inc. (NMS)**: NMS is the company utilized by ASHP to administer the ASHP Match.

**National Committee for Quality Assurance (NCQA)**: is a non-profit organization that accredits many different types of healthcare organizations in the United States, including health plans, pharmacy benefit managers (PBM’s), and specialty pharmacies.

**Non-Traditional Residencies**: Residency programs that, by design, have expanded the length of the residency beyond the traditional 52-week program length.

**PharmAcademic™**: PharmAcademic™ from the McCreadie Group, Inc. is the online tool to support the management of residency program and to provide documentation of a systems-based approach to training for ASHP-accredited residencies. Residency programs are required to use PharmAcademic™.

**Pharmacy Online Residency Centralized Application Service (PhorCAS)**: PhorCAS is a centralized application service which distributes application information to programs to initiate the application process.

**Policy**: A statement of intent that is implemented as a procedure or protocol and is documented in a program’s residency manual or other readily available residency or pharmacy department documents.

**Residency Program Director (RPD)**: The pharmacist responsible for direction, conduct, and oversight of the residency program.

**Site Coordinator**: An individual in a multiple-site residency program who is designated to oversee and coordinate the program’s implementation at an individual site that is used for more than 25% of the learning experiences.

**The Joint Commission (TJC)**: is a non-profit accreditation organization that accredits many different types of healthcare organizations and programs in the United States, with an international branch that accredits medical services around the world.

**Targeted Medication Review (TMR)**: is an ongoing monitoring process with outreach to the patient and/or prescriber about a specific or potential medication-related problem, without comprehensive assessment of the patient’s medications.

**United States Public Health Service (USPHS)**: The United States Public Health Service is a division of the Department of Health and Human Services concerned with public health. Pharmacists in the USPHS are commissioned officers who work throughout the U.S. Department of Health and Human Services and in other Federal agencies and programs—caring for patients; reviewing, approving, and monitoring new drugs; conducting research; and assisting in public health emergencies.
Utilization Review Accreditation Commission (URAC): is a non-profit organization that accredits and provides certifications for many types of healthcare organizations and services including community pharmacies, health plans, infusion pharmacies, mail service pharmacies, and specialty pharmacies.