



## GUIDANCE DOCUMENT FOR THE ACCREDITATION STANDARD FOR POSTGRADUATE YEAR ONE (PGY1) COMMUNITY-BASED PHARMACY RESIDENCY PROGRAMS

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

*Guidance updated March 2021*

### **Guidance Document Introduction**

Interpretation for many sections of the Standard is provided in this Guidance Document in boxes following each section of the Standard. The interpretation is provided to help programs better understand their level of compliance with the Standard and describes how compliance with the Standard will be evaluated by accreditation surveyors. Accreditation decisions are made based on integration of all components of the Standard and their relationship to each other; however, programs that follow the descriptions provided are most likely to have a successful accreditation survey. Components of the Standards that are critical factors are highlighted in bold type (see the Glossary for the definition of “critical factors”).

The “How It Will Be Surveyed” sections in the Guidance Document provide information about how surveyors will review programs during accreditation surveys. In general, programs are surveyed using three processes: (1) review of documentation; (2) discussion with the RPD, preceptors, residents and others; and, (3) observation, such as during a tour of facilities, or other observations. These sections of the Guidance Document include information about documentation that will be reviewed, types of discussions, and observations and tours that will take place.

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

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

Pharmacist residency education and training in community-based practice aims to develop pharmacy leaders who are capable of improving the health of patients within the communities they serve. The primary purpose of this Standard is to foster the development of community-based pharmacist

practitioners<sup>1</sup> who are community-focused practice leaders, serving as an access point for care and having the skillset necessary to provide quality generalist patient care services<sup>2</sup> wherever health and medication needs arise.

Application of the Standard: The requirements serve as the basis for evaluating a PGY1 community-based pharmacy residency program for accreditation. It is recognized that in the application of this Standard, training locations may vary and diverse community-based practices<sup>3</sup> may find utility in the use of this Standard. Additionally, because of the diversity of patient populations, service offerings, and business models, it is recognized that individual practice locations<sup>4</sup> may be unable to provide all of the Standard's requirements for diversity, variety, and complexity; however, it is intended that the combination of all practice locations used for the training of the individual resident meets the requirements as set forth by the Standard and that each resident has a designated community-based home-base<sup>5</sup> practice location.

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

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

### **Overview of the Standards for PGY1 Community-based Pharmacy Residencies**

The following explains the rationale and importance of the areas selected for inclusion in the standards.

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

---

<sup>1</sup> Skelton JB, Owen JA; American Pharmacists Association. Developing a vision and strategic action plan for future community-based residency training. *J Am Pharm Assoc.* 2016 Sep-Oct.45(5):584-589.e1

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

<sup>3</sup> A variety of community-based practices may find utility in the use of this Standard including but not limited to community pharmacies, ambulatory care clinics, physician offices, free clinics, federally qualified health centers, employer-based clinics, assisted-living facilities, hospice, home care, and adult/pediatric hospitals with outpatient pharmacies/clinics.

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

<sup>5</sup> Home-base practice location is the place designated as a resident's primary practice site for residency training.

**Standard 2: Responsibilities of the Program to the Resident**

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

**Standard 3: Design and Conduct of the Residency Program**

It is important that residents' training enables them to achieve the purpose, goals, and objectives of the residency program and become more mature, clinically competent practitioners, enabling them to address patients' needs. Proper design and implementation of programs helps ensure successful residency programs.

**Standard 4: Requirements of the Residency Program Director and Preceptors**

The residency program director (RPD) and preceptors are critical to the residency program's success and effectiveness. Their qualifications and skills are crucial. Therefore, the residency program director and preceptors will be professionally and educationally qualified pharmacists who are committed to providing effective training of residents and being exemplary role models for residents.

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

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

**Standard 6: Pharmacy Practice**

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

## Standard 1: Requirements for Resident Selection and Resident Completion of the Program

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

### Guidance

This procedure is in the residency manual or other readily available pharmacy department documents. The procedure needs to be documented but it does not need to be a formal pharmacy department policy. Predetermined criteria used to evaluate applicants are documented. The procedure should reference the attachments used to evaluate applicants (e.g., screening or scoring forms).

### How it will be surveyed

Review of:

- formal, documented procedure
- predetermined criteria used to select applicants to interview and rank.

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

### How it will be surveyed

Review of procedure and criteria.

Discussion with preceptors/Residency Advisory Committee (RAC) members.

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

### Guidance

This information is included in the criteria required in Standard 1.1 (criteria to evaluate qualifications of applicants).

### How it will be surveyed

Review of:

- residents' Academic and Professional Records
- documented procedure described above in Standard 1.1.

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

### Guidance

Jurisdiction pertains only to federal facilities (e.g., VA, DOD, PHS, IHS, BOP) in which pharmacists may practice as long as they maintain license in any state or U.S. territory.

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

**Guidance**

**1.5 is a critical factor (see Glossary for definition of “critical factor”).**

The policy appears in the residency manual or other readily available pharmacy departments documents.

Program documents how resident’s plan will be modified if the resident isn’t licenses prior to, or within, 90 days. (Examples, dismiss, extend, suspend and restart when licensed).

Programs ensure a minimum of 2/3 of residency is completed as a pharmacist licensed to practice in the program’s jurisdiction. In all circumstances, residents are licensed within 120 days of the start of the program. If not licensed the program dismisses, extends, or suspends the program until licensed.

**How will this be surveyed**

Review of policy

**1.6 Program policies, requirements for successful completion of the program, and expectations of residents in the program are documented.**

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

**Guidance**

**1.6 is a critical factor (see Glossary for definition of “critical factor”).**

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

The following policies and procedures are adequately documented:

- Dismissal policy
- Licensure
- Moonlighting
- Duty hours
- Tracking of duty hours and moonlighting
- Professional, family, sick and extended leave
- Requirements for successful completion of the program

Programs have a list of requirements and expectations for completion of the residency program that include at minimum:

- Successful completion of all required and elective learning experiences
- Achievement of the program’s goals and objectives (% achieved, specific objectives that must be achieved or following the program’s achievement rubric)
- List of required duties and responsibilities
- List of work products requiring completion
- List of required presentations including the number of presentations and the audience for each presentation.

Policies and procedures must be consistent with human resources policies and procedures.

**How it will be surveyed**

Review of documents given to applicants invited to interview prior to or at the interview to determine inclusion of items listed in the Standard.

## Standard 2: Responsibilities of the Program to the Resident

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

### Guidance

Residents taking leave greater than the paid leave (i.e., vacation, sick, holiday) allowed by the organization cannot be awarded a certificate of completion unless that additional leave is made up.

Program policies address whether or not the program will be extended and if the extension will be paid or unpaid. If the organization is not able to extend the program, the policy states that the resident will not receive a certificate of completion.

### How it will be surveyed

Review of:

- residents’ schedules
- extended leave policy
- residency terms and conditions
- documentation of changes to the program duration for residents’ successfully completing the program when leave has exceeded paid leave allowed by the organization

Discussion with RPD and residents about how extended or excessive leave during residency is managed.

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

### Guidance

Programs have a written process for monitoring compliance with the ASHP duty hour requirements. RPDs should review latest duty hour requirements on the ASHP website. Duty hours include time spent at the practice sites used by the program, external moonlighting, academic teaching, and patient care provided on a volunteer basis (e.g., free clinics)

### How it will be surveyed

Review of:

- documentation related to duty hours and the moonlighting policy
- documentation of work hours/schedules, if available

Discussions related to duty-hour practices and procedures.

- 2.3 All programs in the ASHP accreditation process adhere to the *Rules for the ASHP Pharmacy Resident Matching Program (Match)*<sup>3</sup>, unless exempted by the ASHP Commission on Credentialing.

**Guidance**

The following are approved exemptions:

- Indian Health Service (IHS) residency positions.
- Residency positions offered to members of the active forces of the uniformed services (i.e. Army, Navy, Air Force, Marines, and Coast Guard)
- Residency positions offered to commissioned officers of the Public Health Service (PHS)

Residency programs which are exempt from the Match are required to report the number positions filled annually to the ASHP Accreditation Services Office by April 1<sup>st</sup>. 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 must accept or decline residency positions offered through the IHS match process must occur prior to the initial date applicants may submit Rank Order Lists for Phase I of the Match.

**How it will be surveyed**

Review of residents' Academic and Professional Records.

Discussion related to participation in the matching program.

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

**Guidance**

Letter of offer is provided to the resident within 30 days of the match day. The letter will reference the program's website or attachments for any required information not contained in the offer letter. Residents sign and return the offer letter within 30 days of the match day to signify that they understand the list of requirements and expectations of the residency. Transmittal and execution of a contract constitutes acceptance and would be acceptable in place of a letter of acceptance.

**How it will be surveyed**

Review of signed acceptance letter and attachments or review of executed contract to determine compliance with the above stated requirements. Documentation may be in paper or electronic format.

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

**Guidance**

**2.5 is a critical factor (see Glossary for definition of "critical factor").**

There are sufficient number of preceptors available to facilitate achievement of the competencies, goals, and objectives and to guide (model, coach, facilitate) residents for all required and elective learning experiences.

Preceptors assigned as the primary preceptor for a learning experience are qualified to practice in the assigned learning experience.

**How it will be surveyed**

Review of:

- the residency program’s structure documents and learning experience descriptions
- review of preceptors’ roster and academic and professional record form
- residents’ evaluations of preceptors and learning experiences. Discussions with residents and preceptors.

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

**Guidance**

Residents are provided with an area to work and access to computer technology.

Work area is conducive to concentrating without constant interruptions.

Residents are made aware of financial support to attend professional pharmacy meeting(s).

**How it will be surveyed**

Observation by tour of residents’ work area, reference materials, available technology.

Discussion with residents and preceptors about extramural educational opportunities and financial support.

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

**Guidance****2.7 is a critical factor (see Glossary for definition of “critical factor”).**

See Standard 1.6 for guidance on “requirements for completion.”

**How it will be surveyed**

Review of:

- methodology for documentation of residents’ satisfactory completion
- current and past residents’ documentation to determine if requirements were met
- summative evaluations; exit evaluations; residents’ work products/records/files; electronic tracking system; or other methods, such as a checklist of program requirements

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

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

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



**Guidance****2.8 is a critical factor (see Glossary for definition of “critical factor”).**

Until accreditation is achieved no mention of accreditation status should be included on the certificate.

Once the program achieves accredited status, new certificates are issued to residents indicating completion of an accredited residency. Accreditation is retroactive to the date that ASHP received the program’s application for accreditation (candidate status, not pre-candidate status).

Use of ASHP and APhA logos may be used if allowed by the institution and, if used, follow all applicable rules as published by ASHP on the accreditation website.

**How it will be surveyed**

Review of certificate for signatures and wording.

Candidate status programs must provide a draft of current certificate and also a draft of certificate to be issued once accreditation is conferred.

**2.9 The RPD maintains the program’s compliance with the provisions of the current version of the ASHP Regulations on Accreditation of Pharmacy Residencies throughout the accreditation cycle.****Guidance****2.9 is a critical factor (see Glossary for definition of “critical factor”).**

With regard to naming of programs, the following are the accepted names for PGY1 programs. These names must be 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

Variation to the three PGY1 program titles 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.

PGY1 programs are allowed to provide additional information about their program in promotional or program materials but the description should be limited to the practice setting, types of patients seen, or other special characteristics of the program. For example, a program set in an ambulatory clinic is allowed to describe their practice or note that the program is in an ambulatory setting in the program description. As another example, if a program is set in a pediatric hospital, that can also be described in the program description. However, it cannot be part of the program title.

*Per ASHP Regulations on Accreditation of Pharmacy Residencies:*

*Regulation (VIII.F.), “all programs in the accreditation process must use ASHP-approved technology systems to support and maintain the application process (i.e., PhORCAS) and residency program management (i.e., PharmAcademic).”*

Required use of PharmAcademic for residency program management includes:

- Building and maintenance of learning experience descriptions
- Summative, preceptor, and learning experience evaluations;

- Documentation and sharing of resident development plans;
- Close-out procedures to notify ASHP regarding completion/non-completion of enrolled residents, including graduate tracking.
- Upload program certificates.

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 Application Procedures

Review of PharmAcademic

May review 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*.

**Standard 3: Design and Conduct of the Residency Program**

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

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

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

**Guidance**

The program uses the required PGY1 Community-based Pharmacy Residency purpose statement. The program’s design is consistent with the PGY1 Community-Based Pharmacy Residency program purpose statement.

The program develops a brief written description of their program that aligns with the purpose statement of a PGY1 Community-Based residency and elaborates on any unique aspects of their program. The description should not include any modification to the PGY1 community purpose statement that is used for all residency programs.

**How it will be surveyed**

Review to determine that the required purpose statement is being used.

Review of the program’s description and the design of the program.

3.2 Competency Areas, Educational Goals, and Objectives

- 3.2.a The program’s educational goals and objectives support achievement of the residency’s purpose.
- 3.2.b The following competency areas and all associated educational goals and objectives are required by the Standard and must be included in the program’s design:
  - 3.2.b.1 patient care.**
  - 3.2.b.2 leadership and management.**
  - 3.2.b.3 advancement of community-based practice and improving patient care.**
  - 3.2.b.4 teaching, education, and dissemination of knowledge.**

**Guidance**

**3.2.b.1-4 are each a critical factor (see Glossary for definition of “critical factor”).**

The program uses all the required educational goals and objectives.

All required goals and objectives are assigned to the program’s learning experiences.

All required objectives are assigned to be taught and evaluated at least once in required learning experiences. Some objectives, particularly those in R1, may require teaching and evaluation several times during the residency program year to enable residents to achieve competency.

**How it will be surveyed**

Review of documents that describe the program’s structure and indicate which required objectives are assigned to each required learning experience to ensure all are taught and evaluated at least once.

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

**Guidance**

RPD, in coordination with the RAC, determines if additional goals and/or objectives are added to the design of the core program.

Examples of additional goals and/or objectives that may be added to the design of the core program include goals and objectives related to:

- Pharmacy Research
- Added Leadership and Management Skills (e.g., corporate management, regional or district management)
- Transitions of care (e.g., community to hospital, community to assisted and long-term care)
- Home Care
- Public Health
- Managed Care
- Teaching and Learning
- Specialty Pharmacy
- Health, Wellness, and Emergency Preparedness

Programs may add educational goals if sufficient educational objectives are included in the program’s design to allow achievement of the goal.

Programs may also choose educational objectives only to include in the program’s design under existing goals.

Any additional goals and/or objectives added to the program are required for all residents completing the program.

Additional objectives added to the program must not interfere with the requirement that residents spend two-thirds or more of the program in direct patient care activities. (See3.3.d.1)

**How it will be surveyed**

Review goals and/ or objectives added to the program that are required for all residents completing the program. Discuss the impact of the addition of goals and/or objectives on the design of the program (e.g., impact on patient care component, reduction in time on other competencies). Review any goals and/or objectives added to the development plan for an individual resident and discuss impact on a resident’s ability to complete the program.

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

**Guidance**

RPD or designee and each resident determine if additional goals and/or objectives are added to the professional development plan of each resident. Examples of additional goals and/or objectives that may be added to the development plan for a resident include goals and objectives related to:

- Pharmacy Research
- Added Leadership and Management Skills (e.g., corporate management, regional or district management)
- Transitions of care (e.g., community to hospital, community to assisted and long-term care)
- Home Care
- Public Health
- Managed Care
- Teaching and Learning
- Specialty Pharmacy
- Health, Wellness, and Emergency Preparedness

**How it will be surveyed**

Review of resident’s development plans to determine what goals and objectives have been added, plans to achieve the added goals and objectives, and documentation of progress towards achievement of the added goals and objectives.

**3.3 Program Structure and Design**

- 3.3.a The structure of the program is established, described, and formally documented.
- 3.3.a.1 The description includes a list of all required and elective learning experiences.
- 3.3.a.2 The description includes the type (e.g., longitudinal, rotational, extended, concentrated) of each learning experience.
- 3.3.a.3 The description includes the duration for each learning experience.

**Guidance**

A written list of required and elective experiences by type and duration is documented and provided to residency candidates and used to develop individual schedules for residents throughout the year. Longitudinal experiences have a designated length (e.g., year, 4 months, 6 months) and an estimate of average hours spent per week (e.g., 4 hours per week on average, 16 hours per week).

Examples:

- Rotational: Corporate Pharmacy Management: 1 month, 2 days (16 hours) per week.
- Longitudinal: Patient Care Services: 12 months, 2 days (16 hours) per week.

The program should estimate the total % emphasis of time per competency area.

**How it will be surveyed**

Review of the written program structure that is provided to residents and used by the program.

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

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

**Guidance**

Residents must have sufficient opportunities to develop proficiency to provide all required pharmacy services. Residency program directors must review the scope and depth for each of the required services at the site(s) used by the program to determine the potential for residents to develop proficiency to provide each required service.

If the site(s) used by the program for any of the required services has a limited number of enrolled patients, the residency program director is responsible for identifying additional opportunities for residents to meet the requirements to provide patient care services.

Preceptors for learning experiences for required pharmacy services must follow the service requirements detailed in Standard 6.3.b.

**3.3.c.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;**

**Guidance**

**3.3.c.1 is a critical factor (see Glossary for definition of “critical factor”).**

The use of the term comprehensive medication management in the context of the 2016 PGY1 Community-based Accreditation Standard refers to Medication Therapy Management (MTM). MTM is a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

The core elements of a medication therapy management service in pharmacy practice includes the following:

- Medication therapy review (MTR)
- Personal medication record (PMR)
- Medication-related action plan (MAP)
- Intervention and/or referral (e.g., referral to another provider for evaluation and diagnosis, referral to a support service or program for disease state education/management, or referral to a monitoring program for high risk medications)
- Documentation and follow-up (e.g., collaboration and communication with prescribers and patients to resolve medication-related problems and scheduling follow-up, virtual or face-to-face, appointments with patients when needed to monitor the action plan)

For the purpose of the 2016 Standard, the expectation is that MTM Core Elements will be used when providing Comprehensive Medication Reviews (CMR) and Targeted Medication Reviews (TMR). Whether comprehensive or targeted, the individual patient’s medications are evaluated in the context of the patient as a whole, taking into consideration all of the patient’s conditions and medication therapies.<sup>2</sup>

Comprehensive medication reviews (CMRs) following the MTM Core Elements service model may be incorporated into a number of services including, but not limited to:

- Adherence and medication synchronization services
- Medicare Part D MTM annual reviews
- MTM platforms (e.g., Outcomes/PharmMD/Humana)
- Medication reconciliation with comprehensive medication reviews in clinic settings
- Medicare Annual Wellness Visits

Targeted medication reviews following the MTM Core Elements service model may be incorporated into a number of services including, but not limited to:

- Targeted interventions using MTM platforms
- Targeted interventions for populations such as
  - pneumococcal vaccinations for patients over the age of 55
  - statins for patients with diabetes
  - adherence to antipsychotics and antidepressants
  - use of controller medications in asthma
  - yearly TSH measurements for patients on thyroid replacement medications
  - depression screening in patients with chronic diseases
  - interventions for poorly controlled patients with hypertension or diabetes
  - monitoring programs for weight, SOB, edema for patients with CHF

Regardless of the type of practice at the home-base practice site (i.e., chain, independent, specialty, home-infusion, long term care, outpatient clinic, FQHC, physician's office, etc.) and other practice sites used in the training of residents, CMRs focus on the care of patients with chronic disease states. The total number of CMRs completed by the resident includes **at least three** chronic disease states from the following list<sup>3</sup>:

- Alzheimer disease
- Arthritis
- Chronic heart failure
- Diabetes
- Dyslipidemia
- End-stage renal disease
- Hypertension
- Mental health
- Respiratory disease

#### **How it will be surveyed**

- 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
- Discussion with preceptors and residents

### **3.3.c.2 health and wellness;**

#### **Guidance:**

**3.3.c.2 is a critical factor (see Glossary for definition of “critical factor”).**

Community pharmacies are strategically important settings that deliver services aimed at promoting health and creating wellness by preventing disease. Residents gain experience in health and wellness services that are conducted with patients at the practice site as well as in

the community. The resident gains experience with at least **three** health and wellness services during the residency program. Examples of services 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

### **3.3.c.3 immunizations;**

#### **Guidance**

**3.3.c.3 is a critical factor (see Glossary for definition of “critical factor”).**

Residents should:

- understand the pharmacology to immunize patients for bacteria and viruses;
- immunization techniques;
- administration timing and boosters if needed;
- and the side effects and allergic reactions that may occur from administration of immunizations.

Required readings may be used to ensure residents have the knowledge and understanding to safely administer immunizations. Preceptors should:

- review the policies, procedures, and forms used by the immunization practice site(s) with residents;
- provide role modeling to residents on how to administer each type of immunization at the site;
- coach residents as needed before the resident independently administers immunizations;

Resident must have sufficient opportunities administering a variety of immunizations (both IM and SQ), at sites used for the program, to develop proficiency in interacting with patients before and after administering immunizations.

Residents are required to administer at least **three** types of immunizations, which may include, but are not limited to:

- Influenza
- Tetanus
- Diphtheria, Pertussis (Tdap)
- Diphtheria (Td)
- Varicella (chickenpox)
- Human papillomavirus (HPV, 3 doses)
- Zoster (shingles)
- Measles, mumps, and rubella (MMR)
- Pneumococcal disease
- Hepatitis A
- Hepatitis B

#### **How it will be surveyed**

- Review examples of patient immunization documentation by residents
- Review immunization policies and procedures

- Discuss immunization role modeling provided by preceptors to the resident
- Verify that the resident has administered at least three types of immunizations
- Review immunization data from the service grid

### 3.3.c.4 disease state management incorporating medication management;

#### Guidance

#### 3.3.c.4 is a critical factor (see Glossary for definition of “critical factor”).

Over the course of the residency, residents’ training provides opportunities to gain an understanding of the components of disease state management and the role of the pharmacist in managing chronic diseases. In addition, residents develop the knowledge, skills, abilities, and competencies to perform disease state management, incorporating the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists’ Patient Care Process (PPCP).

Disease state management performed by pharmacists includes collaboration with patients and/or caregivers and members of the healthcare team to optimize patient outcomes through the use of evidence-based medicine to identify, prevent, and resolve medication-related problems and improve quality of life through achievement of therapeutic goals.

Disease state management is required in all community-based practice settings. For example, services may be provided by pharmacists:

- practicing within the same location as other members of the interdisciplinary team by using documented procedures or protocols, collaborative practice agreements, or prescriptive authority. Examples of these practice settings may include, but are not limited to Federally Qualified Healthcare Centers (FQHCs), hospital outpatient pharmacies and clinics, or physician group practices with a pharmacy within the medical office or building.
- practicing in a different location from other members of the interdisciplinary team, where they partner with one physician or a physician group practice by using documented procedures or protocols, collaborative practice agreements, or prescriptive authority. Initial disease state management services may begin with providing care to patients for one physician. As services expand, partnerships with other physicians may develop with provision of care expanding to additional patients and a variety of disease states. Examples of these practice settings include, but are not limited to independent, chain, and specialty pharmacies.

#### Role of the Pharmacist in Disease State Management, incorporating the JCPP PPCP, includes:

- \* Collect
  - Gather all the pertinent and relevant patient information (objective and subjective) necessary to manage the patient.
  - Review medical records, including pertinent laboratory data.
  - Interview patients and/or caregivers.
- \* Assess
  - Assess current status of disease state(s).
  - Analyze patient information obtained via patient interview and review of medical records.
- \* Plan
  - Establish patient-specific goals (in collaboration with the multidisciplinary healthcare team)
  - Develop care plan(s), including non-pharmacologic and pharmacologic treatment (i.e., initiate, modify, and discontinue therapy).
- \* Implement



- Educate patients and/or caregivers regarding disease state(s).
- Educate patients and/or caregivers regarding care plan.
- Document care plan in the permanent medical record.
- Include communication of care plan to interdisciplinary healthcare team.
- \* Follow-up: Monitor and Evaluate
  - Monitor disease state(s) and progress towards established therapeutic goals.
  - Order relevant and pertinent laboratory tests, as needed.
  - Schedule follow-up visit(s) with pharmacist or refer patients to specialist or other healthcare provider, as necessary.

Regardless of the type of practice at the home-base site (i.e., chain, specialty, home-infusion, and independent) and other practice sites used, training of residents with regard to disease state management includes **at least three** of the following chronic disease states<sup>5</sup>:

- Alzheimer disease
- Arthritis
- Chronic heart failure
- Diabetes
- Dyslipidemia
- End-stage renal disease
- Hypertension
- Mental health
- Respiratory disease

#### **How it will be surveyed**

- Review examples of de-identified progress notes authored by residents, demonstrating provision of disease state management
- Discuss incorporation of the JCPP PPCP in the provision of disease state management during patient encounters
- Verify that residents' disease state management training includes at least three of the chronic disease states specified in Guidance (see above)
- Review disease state management data from the service grid

### **3.3.c.5 care transitions incorporating medication reconciliation and medication management; and,**

#### **Guidance**

**3.3.c.5 is a critical factor (see Glossary for definition of "critical factor").**

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

### **3.3.c.6 patient-centered medication distribution.**

- 3.3.d The structure permits residents to gain experience and sufficient practice with diverse patient populations with a variety of disease states and conditions, and diverse range of patients' medication treatments and health-related needs.
  - 3.3.d.1 Residents spend two-thirds or more of the program in patient care activities.**
  - 3.3.d.2 Residents spend no more than one-third of the twelve-month PGY1 pharmacy residency program in a practice or environment providing care to a specific patient disease state and population (e.g., diabetes, hypertension, hyperlipidemia, asthma, anticoagulation).**
  - 3.3.d.3 Residents gain practice and experience in longitudinal patient care delivery and the development of extended patient relationships.**
  - 3.3.d.4 Residents function and work as a member of the health care team.
  - 3.3.d.5 Residents provide patient care in settings and environments with and without access to existing sources of complete patient health data.
  - 3.3.d.6 Residents appropriately document patient care in the patient's health care record.**
  - 3.3.d.7 Residents use technology including electronic health record functionality.,
  - 3.3.d.8 Residents progress over the course of the residency to become more efficient and effective with the ability to work independently as patient care providers.

**Guidance**

**3.3b, 3.3.c.1, c.2, c.3, c.4, c.5, and c.6 are each a critical factor and 3.3.d.1, d.2, d.3 and d.6 are each a critical factor (see Glossary for definition of "critical factor").**

Structure includes at least 2/3 of residents' time being spent in patient care.

Residents obtain experience in all the listed types of patient care. The program may use more than one practice location to achieve the patient care requirements.

Program may use up to four additional practice locations beyond the home-based organization to achieve the program's educational goals and objectives.

Residents participate in one or more learning experience where they gain practice and experience in longitudinal care by seeing the patient for follow up visits and having the opportunity to establish relationships with providers and patients.

Residents provide patient care in environments with access to electronic records and rich patient data as well as in environments with minimal access to patient health data where they must determine how to access needed data and make decisions with limited data.

**Patient Care by Community Pharmacists includes:**

Activities performed by community 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, and is achieved directly with patients and caregivers face-to-face, telephonically, virtually, or in writing. (See *Glossary for related references.*)

**Examples of patient care activities include, but are not limited to, this list:**

- Completing comprehensive medication reviews (i.e., thorough review of the medication profile, medication history, medication adherence of patients and interviewing patients to obtain additional patient medication information).
- Providing health, wellness, and immunization services.
- Performing drug therapy management (e.g., diabetes, hypertension, hyperlipidemia, asthma, anticoagulation) and participating in disease state management services.
- Collecting and organizing patient-specific information needed by the pharmacist to prevent, detect, and resolve medication-related problems and to make appropriate evidence-based, patient-centered medication therapy recommendations as part of the interdisciplinary team.
- Specifying therapeutic goals for patients incorporating the principles of evidence-based medicine that integrate patient-specific data, disease and medication-specific information, ethics, and quality-of-life considerations.
- Designing patient-centered regimens and monitoring plans that meet the evidence-based therapeutic goals established for patients, which integrates patient-specific information, disease and drug information, ethical issues and quality-of-life issues, and considers pharmacoeconomic principles.
- Recommending or communicating patient-centered, evidence-based therapeutic regimens and corresponding monitoring plans to other members of the interdisciplinary team and patients in a way that is systematic, logical, accurate, timely, and secures consensus from the team and patient.
- Initiating, when appropriate, the patient-centered, evidence-based therapeutic regimen and monitoring plan for patients according to the organization's policies and procedures.
- Assessing patients' progress toward therapeutic goal(s) and, when necessary, redesigning a patient-centered, evidence-based therapeutic plan as necessary based on evaluation of monitoring data and therapeutic outcomes.
- Using effective patient education techniques to provide education and counseling to patients and caregivers, including information on medication therapy, adverse effects, compliance, appropriate use, handling, and medication administration.
- Providing medication reconciliation and medication management during care transitions.
- Providing follow up care for monitoring, managing, and referring to other providers.
- Other activities that include an estimated amount of time devoted to patient care (e.g., population health using tele-pharmacy, patient care component associated with a resident project).

**How it will be surveyed**

Review of:

- the program's structure and residents' schedules
- learning experience descriptions

Discussion with preceptors, residents, and other health care providers.

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

- 3.3.e.1.1 a general learning description synopsis, that includes the practice area and the roles of pharmacists in the practice area;
- 3.3.e.1.2 expectations of residents;
- 3.3.e.1.3 educational goals and objectives assigned to the learning experience;
- 3.3.e.1.4 for each objective, a list of learning activities that will facilitate its achievement; and,
- 3.3.e.1.5 a description of evaluations that are to be completed by preceptors and residents.

**Guidance**

**3.3.e.1 is the critical factor (see Glossary for definition of “critical factor”). Any item in 3.3.e.1.1 through 3.3.e.1.5 may be used as a reason for citing of 3.3.e.1**

Learning experience descriptions are developed by preceptors for all required and elective learning experiences under guidance of the RPD, and/or oversight by the RAC.

Learning experience descriptions are documented in PharmAcademic.

Learning experience descriptions describe how residents will progress and the expectation for their skill development over time and in any repeated learning experiences. Expectation requirements include progression of the resident over the period of the learning experience (e.g., rotation, longitudinal). Residents should progress over the course of the learning experience to be more efficient, effective, and able to work independently in providing patient care. If a successfully completed learning experience is repeated (e.g., Patient Care 1 and Patient Care 2), the preceptor elevates the expectations for the resident during the repeated experience. Progression timelines are documented in each learning experience.

Learning activities are specific, unique to the objective, and developed at the cognitive learning level (Bloom’s Taxonomy) associated with the objective.

Learn more at: <http://www.ashpmedia.org>

Resource: Template for learning experience descriptions and example activities on ASHP website.

**How it will be surveyed**

Review of learning experience descriptions in PharmAcademic.

Discussion of reasons for second learning experience in an area, if residents have completed the same learning experience a second time.

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

**Guidance**

Orientation includes:

- the residency’s purpose and practice environment
- the appropriate accreditation standards, competencies, goals and objectives
- design of the residency program including all program requirements
- description of required and, if applicable, elective learning experiences
- evaluation strategy and process (see standard 3.4)
- residency manual (if applicable)
- residency policies, terms and conditions, e.g., requirements for completion, moonlighting, duty hours, dismissal

- considering education to the resident during orientation on burnout syndrome, the risks and mitigation strategies. Resources available on the ASHP website can be found here: <https://www.ashp.org/wellbeing>

Structure includes orientation as a learning experience.

**How it will be surveyed**

Review of:

- where orientation appears in the residency calendar, if applicable
- learning experience description for orientation
- orientation schedule and materials given to residents
- residency manual, if applicable

Discussion with residents.

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

**Guidance**

Preceptors review learning experience descriptions with residents during the orientation to each learning experience.

**How it will be surveyed**

Discussion with residents and preceptors.

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

**Guidance**

Preceptors assume the appropriate preceptor roles based on the time of the year and residents' progression.

- Direct instruction appropriate for residents (as opposed to students), when needed.
- Modeling of practice skills described in the educational objectives.
- Coaching skills described in the educational objectives, providing regular, on-going feedback.
- Facilitating by allowing resident to assume increasing levels of responsibility for performance of skills with indirect support of the preceptor as needed.
- Residents function independently in each competency area by the conclusion of the residency program.

**How it will be surveyed**

Review of learning experience descriptions.

Discussion with residents, preceptors, and RPD.

3.4 Assessment and Evaluation Requirements

3.4.a RPD and Preceptor Evaluation Requirements

3.4.a.1 Initial Evaluation

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

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

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

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

**Guidance**

The initial self-evaluation includes professional strengths and weaknesses in terms of educational background as well as in the knowledge, skills, and abilities related to the objectives of the residency. Programs may use their own customized assessment methods such as assessment checklists, case discussions, other checklists, interviews with residents, observation, other methods or combination of methods, or use of tools available in PharmAcademic®. The initial assessment is completed during orientation. The RPD incorporates relevant findings from the initial assessment in the initial development plan for each resident.

**3.4.a.2.1 is a critical factor (see Glossary for definition of "critical factor").**

Verbal and written formative feedback is essential for residents' skill development. Verbal formative feedback is required. Written formative feedback is required when a resident is not progressing satisfactorily.

Feedback should be qualitative, and criteria based.

Frequency of ongoing formative feedback varies based on residents' progress and time of the year. Formative feedback may be written or commented upon electronically on documents used in the program, such as comments on residents' SOAP notes or on evaluations of residents' presentations, projects, monographs, etc.

Residents who are not progressing according to expectations receive more frequent formative feedback.

Specific recommendations for improvement and achievement of objectives are documented for residents who are not progressing satisfactorily.

Preceptors ensure residents' responsibilities and/or activities align with residents' progress within each learning experience.

**How it will be surveyed**

Review of:

- written examples of formative feedback, if applicable.
- assessment strategy as documented in the program design and/or learning experience descriptions.

Discussion with residents and preceptors.

3.4.a.3 Summative Evaluation

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

**Guidance**

**3.4.a.3.1 is a critical factor (see Glossary for definition of “critical factor”).**

RPD and preceptors or RAC define and document evaluation ratings (i.e., define what achieved (ACH), satisfactory progress(SP), and needs improvement(NI), and achieved for the residency (ACHR) mean; define what 1 to 5 ratings on an ordinal scale mean; or define ratings for other scales used for the program)

The example criteria provided for each objective in the PGY1 Community-Based Competencies, Goals, and Objectives are intended to assist preceptors and residents to identify specific areas of successful skill development and areas requiring performance improvement. Preceptors may also develop their own criteria to assess resident performance, identify areas requiring performance improvement, and meet the intent of the standard.

Qualitative written comments:

- are specific and actionable.
- recognize residents’ skill development and progression towards achievement of goals and objectives during a learning experience.
- include recommendations that focus on how residents may improve their performance.

Evaluations are completed by the due date or within 7 days.

**How it will be surveyed**

Review ratings and comments made to recognize strengths and/or need for improved performance.

Determination of timeliness by reviewing summative evaluation dates in PharmAcademic® reports or other reports if PharmAcademic® is not used.

Discussion with preceptors and residents.

Determination of the quality of summative evaluations by:

- review of explanation of ratings (e.g., achieved, satisfactory, needs improvement).
- review of criteria-based feedback in written summative evaluations.

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

**Guidance**

If multiple preceptors, one preceptor should be identified as the primary preceptor.

Programs determine if they will have each preceptor complete a separate evaluation in PharmAcademic® or if all preceptors will provide input to the primary preceptor who will document the joint evaluation.

The primary preceptor obtains consensus of preceptors to determine final ratings and co-sign evaluations.

**How it will be surveyed**

Review of summative evaluations.

Discussion with preceptors and/or residents.

3.4.a.3.1.2 For longitudinal learning experiences greater than twelve weeks but less than six months in length, a

documented summative evaluation is completed at least twice, at the midpoint and end of the experience. For those greater than six months, summative evaluations are conducted quarterly (every three months) and at the conclusion of the learning experience.

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

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

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

3.4.b Development Plan Requirements

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

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

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

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

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

3.4.b.2 Quarterly Update of Development Plan

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

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

**Guidance**

**3.4.b.1.1.1, 3.4.b.1.1.3 and 3.4.b.2.1 are critical factors (see Glossary for definition of “critical factor”).**

The purpose of resident development plans is to modify the design and conduct of the program to address each resident’s unique learning needs and interests.

Development plans also provide a tool for monitoring, tracking, and communicating about residents’ overall progress throughout the residency, and adjustments made to meet their learning needs.

The program’s residency advisory committee meets at least quarterly to discuss overall progress by residents and agree to development plan adjustments needed for residents. Adjustments are reflected in the quarterly updates to the plan.

The following is included in the development plan for each resident:

***Initial assessment by the resident, RPD, and/or designee and/or preceptor(s).***

Residents review the design and conduct of the program and complete an initial self-evaluation for use in developing their plan.

The initial self-evaluation includes the following information:



- Short- and long-term career goals (*optional*).
- Incoming strengths (*required*).
  - Professional strengths in terms of knowledge, skills, and abilities related to the educational goals and objectives.
  - Personal strengths related to being a professional.
- Incoming areas for improvements (*required*).
  - Professional areas for improvement in terms of knowledge, skills, and abilities related to the educational goals and objectives
  - Personal areas for improvement related to being a professional
- Incoming learning interests related to required or elective learning opportunities (*optional*).

Programs may use their own customized assessment methods such as residents' self-assessment checklists, case discussions, other checklists, interviews with residents, observation, other methods or combination of methods, or use of tools available in PharmAcademic®.

The initial self-assessment is completed before or during the beginning of the residency, and information is collected and analyzed during orientation.

***An initial development plan is created for each resident (generally within the first 30 days of the residency by the RPD (and/or designee), discussed with each resident, and may be reviewed by the RAC.***

Adjustments to initial resident development plans include the following as appropriate:

- Modification of residents' schedules.
- Preliminary determination of elective learning experiences.
- Educational goals and objectives to be emphasized in required and elective learning experiences.
- Addition of goals and objectives to required or elective learning experiences.
- Changing and/or increasing summative self-evaluations, formative self-evaluations, and preceptors' feedback related to areas for improvement.
- Modify preceptors' use of modeling, coaching, and facilitation.

Summaries of initial development plans are shared with residents' preceptors.

***1<sup>st</sup>, 2<sup>nd</sup>, and 3<sup>rd</sup> quarter updates***

The quarterly updates are completed, discussed with each resident, and documented every 90 days from the start of the residency (e.g. October, January, and April).

Adjustments are made based upon review of residents' performance (including effectiveness of the previous plan), relevant to the previous quarter's plan with input from preceptor(s) and residents; the identification of new strengths or areas for improvement and, optionally, changes in residents' short- or long-term career goals and interests. If there is no need for changes in the development plan, this is documented.

Development plans do not require a separate evaluation of objectives on a quarterly basis.

It is important to note that the assessment information collected about a resident is a component of the development plan, but is not the plan itself.

***Quarterly review of residents' progress in achieving the competencies, goals and objectives of the program and the resident professional development plans.***

A system is used to track goals and objectives achieved, areas for improvement, and expected progress relative to the time of the year.

A system is used to track adjustments to and the effectiveness of adjustments documented in development plans.

The initial development plan and quarterly updates to the development plan must be uploaded and shared through PharmAcademic.

### How it will be surveyed

Review of resident development plans in PharmAcademic:

- for initial assessments and plans
- for assessments of/and changes to initial development plans after each quarter
- to determine if adjustments to resident development plans appear appropriate for dates
- Discussion with RPD, preceptors, and residents

#### 3.4.c Resident Evaluation Requirements

##### 3.4.c.1 Self-Reflections

3.4.c.1.1 Residents complete a written statement of self-reflection at the beginning of the residency to identify learning expectations and desired areas of professional growth.

3.4.c.1.2 Residents complete a written statement of self-reflection at the conclusion of the residency program to identify competencies achieved, competencies requiring additional attention, and a plan for future professional development.

### Guidance

For compliance with the Standard, self-reflection is considered to be an exercise in self-examination and introspection. It is the resident's global view of his/her learning in which the resident reflects on professional growth over time and aspirations for the future.

The intent of the standard is for each resident to complete a **written statement at the beginning** of the residency prior to the creation of the initial resident development plan reflecting on what the resident identifies as learning expectations for the residency and desired areas for professional growth during the residency. The RPD will review and may use information from the resident's self-reflection along with other assessment information to create the initial development plan.

Beginning residency self-reflection sample questions:

- \* What have been my major accomplishments as I enter residency?
- \* What do I want to accomplish during residency?
- \* What are my personal goals?
- \* What are my personal strengths and weaknesses?
- \* How do I plan to use my personal strengths and overcome my personal weaknesses?

The intent of the standard is for each resident to complete a **written statement during the last month** of the residency reflecting from their own perspective on what competencies they have achieved, what competencies require additional attention, and creating a written plan for future professional development based on competencies requiring additional attention.

End of residency sample self-reflection questions:

- \* What were your major accomplishments during residency?
- \* What personal challenges did you encounter and how did you overcome them?
- \* What was especially satisfying?
- \* What did you learn about yourself?
- \* What would you change if you could do residency over?
- \* Having completed the residency, how have your goals changed?

### How it will be surveyed

Review of beginning of residency and end of residency self-reflection statements completed by residents.

- 3.4.c.2 Initial Self-Evaluation
  - 3.4.c.2.1 Residents complete a self-evaluation of their entering knowledge and skills related to the educational goals and objectives.
- 3.4.c.3 Formative (Ongoing, Regular) Self-Evaluation
  - 3.4.c.3.1 Residents practice criteria-based, formative self-evaluation for aspects of their routine performance.**
- 3.4.c.4 Summative Self-Evaluation**
  - 3.4.c.4.1 The program has a defined plan for the resident to complete and document criteria-based, summative self-evaluation toward achievement of targeted objectives in learning experiences.
  - 3.4.c.4.2 Residents are taught how to perform self-evaluation.

**Guidance**

**3.4.c.3.1 and 3.4.c.4 are critical factors (see Glossary for definition of “critical factor”).**

The RPD and residents will be able to describe how residents perform formative self-evaluations.

**General Guidance for Self-Evaluation**

For compliance with the Standard, self-evaluation is considered to be a criteria- referenced, directed process during which the resident judges the quality of his/her work and learning; identifies strengths and weaknesses in their work and revises accordingly.

“Progress toward achievement of a specific objective is assessed using criteria. The use of criteria-based evaluations is required by the Standard for both formative and summative self-evaluation. The example criteria provided for each objective in the PGY1 Community-based Competencies, Goals, and Objectives are intended to help preceptors and residents identify specific areas of successful skill development and areas requiring performance improvement. Preceptors may also develop their own criteria to assess resident performance, identify areas requiring performance improvement, and meet the intent of the standard.” (From the Required Competency Areas, Goals, and Objectives for Postgraduate Year One (PGY1) Community-Based Pharmacy Residencies).

**Guidance 3.4.c.2.1**

The intent of the standard is for each resident to complete a self-evaluation at the beginning of the residency where residents compare their current knowledge and skills against the PGY1 Community-based goals and objectives. Any objective self-evaluated as being at a lower level of performance the resident should describe their experiences and needs for self-improvement. Information from the self-evaluation should be used by the RPD or designee in creating the initial resident development plan.

**Guidance 3.4.c.3.1**

The intent of the standard is for each resident to practice providing criteria-based formative self-evaluation on activities performed throughout a learning experience. Formative evaluation may be verbal or written. Self-evaluation helps the resident identify areas needing improvement and areas of positive growth occurring during the learning experience. By comparing their formative self-evaluation to that of the preceptor, residents develop ability to self-monitor their performance.

- Residents use applicable criteria to perform formative self-evaluations.
- Preceptors require residents to practice verbal criteria-based self-evaluation during each learning experience.
- Preceptors teach residents how to self-evaluate their performance through modeling, coaching and facilitation.

- Preceptors require residents to verbally compare their self-evaluation to the formative evaluation provided by preceptors and identify differences.

**Guidance 3.4.c.4**

**3.4.c.4 is critical factor (See Glossary for definition of “critical factor”).**

RPD & RAC develop and document a plan for summative self-evaluations.

- The intent of the Standard is for each resident to complete and document a criteria-based summative self-evaluation at the end of each learning experience (or at least quarterly if a longitudinal rotation). The preceptor and resident decide prior to the time of summative evaluations which objectives the resident will target to self-evaluate. Not all objectives are required by the standard to be self-evaluated. However, the RPD and RAC, as in the past, may require residents to self-evaluate against all the goals and objectives that have been assigned by preceptor for each learning experience.
- Prior to the time of summative evaluation, the preceptor) determines which goals and objectives from the learning experience that will be used.
- Preceptors & residents use predetermined criteria describing optimal performance to provide criteria-based assessment and feedback.
- Preceptors and residents document evaluations independently.
- Preceptors and residents compare and discuss residents’ performance against set criteria and where there are differences.
- Preceptors provide feedback to residents on how to improve their ability to self-evaluate their performance.
- Preceptors provide feedback to the RPD on the residents’ ability to perform summative self-evaluations for use in the documentation in the residents’ development plan.
- Completed summative self-evaluations are signed by the resident, co-signed by the learning experience preceptors, and reviewed by the RPD or designee,
- Residents complete summative self-evaluations that include comments about objectives (strengths, areas for improvement).

**How will be surveyed.**

Discussions with RPD, preceptors, and residents.

Review examples of resident initial self-evaluations, formative self-evaluations and summative self-evaluations

Note: 3.4.c.4.1 and 3.4.c.4.2 may be used to cite 3.4.c.4

3.4.c.5 Resident Evaluation of Preceptor

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

**Guidance**

All preceptors listed as preceptors in a learning experience are evaluated by residents at least once. If the resident is evaluating a preceptor who is assigned to more than one longitudinal learning experience, the resident should specify which learning experiences the evaluation addresses and references responses and comments specifically to a learning experience when applicable.

Evaluations are completed by the due date or within 7 days.

Residents' provide constructive feedback to preceptors to help them improve their performance.

**How it will be surveyed**

Review of:

- residents' evaluations of preceptors
- adherence to the program's assessment strategy

Discussion with preceptors and residents.

Timeliness will be surveyed by reviewing preceptor evaluation dates in PharmAcademic® reports.

### 3.4.c.6 Learning Experience Evaluations

3.4.c.6.1 Residents complete an evaluation of each learning experience at the end of the learning experience.

3.4.c.6.2 For longitudinal learning experiences greater than twelve weeks in length, learning experience evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.

3.4.c.6.3 The preceptor(s) and resident discuss the learning experience evaluation.

3.4.c.6.4 Completed learning experience evaluations are signed by the preceptor(s) and reviewed and cosigned by the RPD or designee.

**How it will be surveyed**

Review of:

- residents' evaluations of learning experiences
- adherence to the program's assessment strategy (e.g., timeliness of completion, frequency and content of narrative comments, use of evaluation ratings)

Discussion with preceptors and residents.

Timeliness will be surveyed by reviewing learning experience evaluation dates in PharmAcademic® reports.

## 3.5 Continuous Residency Program Improvement

3.5.a. The RPD, residency advisory committee (RAC), and pharmacy executive must engage in an on-going process of assessment of the residency program including a formal annual program evaluation.

3.5.b. The RPD or designee must develop and implement program improvement activities to respond to the results of the assessment of the residency program.

3.5.c. The residency program's continuous quality improvement process must evaluate whether residents fulfill the purpose of a PGY1 pharmacy residency program through graduate tracking.

3.5.c.(1) Information tracked must include initial employment, and may include changes in employment, board certification, surveys of past graduates, or other applicable information.

**Guidance**

Programs develop their own process for program quality improvement.

Examples:

- residency advisory committee (RAC) meetings at the end of every residency year to discuss areas of strength, opportunities for improvement, and strategies to improve the residency program
- retreats
- focused meetings
- meetings with residents asking their feedback at the end of the residency year
- survey instruments (e.g., preceptor self-assessment, resident evaluations' of RPD)

For 3.5.c.(1), regarding initial employment, the employment environment may be noted and taken into account. PharmAcademic is used for the tracking of initial employment.

**How it will be surveyed**

Review of:

- minutes of RAC meetings in which residency program improvements have been discussed, if applicable
- Any documentation of program assessments, instruments, plans for improvement, etc., if available.
- information obtained about graduates
- Graduate tracking report in PharmAcademic

Discussion about the program's continuous quality improvement efforts.

**Standard 4: Requirements of the Residency Program Director and Preceptors****4.1 Program Leadership Requirements**

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

**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](mailto: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™
- Discussion with RPD

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

**Guidance**

The RAC is composed of a cross section of clinical, operational, and administrative preceptors. The program director establishes a process to choose members. The intent of 4.1.a.1 is to ensure that program leadership and preceptors are engaged in design and oversight of individual residency programs.

**How it will be surveyed**

Review of preceptor and RAC roster.  
Review of meeting agendas and meeting minutes, if available.

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

**Guidance**

The terms used (e.g., Assistant Program Director, Residency Program Coordinator) and definition of roles are determined by the RPD and can vary by program.

Individuals may be delegated responsibilities, with oversight by the RPD, to help lead and manage the residency program. Delegated responsibilities are understood by preceptors and residents of the program.

The term “Site Coordinator” refers to an individual in multi-site programs. The definition is included in the glossary in the PGY1 Community-Based Residency standard.

- 4.1.b Each residency program has a designated sponsoring organization.
- 4.1.b.1 For residencies conducted by one organization, that organization is the designated sponsoring organization.
- 4.1.b.2 When a residency is conducted by more than one organization (two organizations in partnership, such as a college of pharmacy, company, or health system), the partners will agree to and designate the sponsoring organization in a formal agreement.
- 4.1.b.2.1 The agreement includes definition of:
- 4.1.b.2.1.1 responsibilities of all partners;
  - 4.1.b.2.1.2 responsibilities of the RPD; and,
  - 4.1.b.2.1.3 the RPD’s accountability to the organizations.

4.2 Residency Program Directors (RPD)

**4.2.a Eligibility of the RPD**

An RPD is a licensed pharmacist who:

- has completed an ASHP-accredited PGY1 residency and a minimum of three years of pharmacy practice experience in a community or ambulatory practice environment; or,
- has completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience in a community or ambulatory practice environment; or,

- has not completed an ASHP-accredited residency, but has five or more years of pharmacy practice experience in a community or ambulatory practice environment.

**Guidance**

**4.2a is a critical factor (see Glossary for definition of “critical factor”).**

The RPD’s pharmacy practice experience is relevant to the practice setting in which the residency is conducted (e.g., community pharmacy, hospital based outpatient or community pharmacies, federally funded community health centers).

4.2.b Qualifications of the RPD

RPDs serve as role models for pharmacy practice, as evidenced by:

**4.2.b.1 leadership within the pharmacy department or within the organization through a documented record of improvements in and contributions to pharmacy practice;**

**Guidance**

**4.2.b.1 is a critical factor (see Glossary for definition of “critical factor”)**

Examples of leadership (should have been demonstrated within the last five years):

- contribution to the development of policies/guidelines or protocols
- implementation of a new service at the practice site
- demonstrated leadership within the pharmacy department or organization or school of pharmacy such as leading a committee/initiative, team leader, management position, etc.

**How it will be surveyed**

Review of academic and professional record form or PharmAcademic® review.

**4.2.b.2 demonstration of ongoing professionalism and contribution to the profession; and,**

**Guidance**

**4.2.b.2 is a critical factor (see Glossary for definition of “critical factor”)**

Examples of demonstrating ongoing professionalism and contribution to the profession (should have been demonstrated within the last five years):

- serving as a reviewer (e.g., contributed papers, grants, or manuscripts; reviewing/submitted comments on draft standards/guidelines for professional organizations)
- presentation/poster/publication in professional forums
- poster/presentation/project co-author for pharmacy students or residents at a professional meeting (local, state, or national)
- active service, beyond membership in professional organizations at the local, state, and/or national level (e.g., leadership role, committee membership, volunteer work)
- faculty or pharmacy student preceptor appointment
- professional consultation to other health-care facilities or professional organizations
- contributing to health and wellness in the community and/or organization through active, ongoing participation in health fairs, public events, employee wellness promotion/disease prevention activities, population-based care management, etc.

**How it will be surveyed**

Review of academic and professional record form or PharmAcademic® review.



#### 4.2.b.3 Participation in workgroups or committees within the organization.

##### **Guidance**

**4.2.b.3 is a critical factor (see Glossary for definition of “critical factor”)**

Examples (demonstrated in the last five years):

- active participation on a committee, taskforce or other workgroup of the pharmacy (independent, chain, outpatient clinic/facility, etc.)
- active participation on a college of pharmacy committee (This does not include participation in the RAC.)

##### **How it will be surveyed**

Review of academic and professional record form or PharmAcademic® review.

#### 4.2.c Leadership Responsibilities of the RPD

RPDs serve as designated and authorized leaders of the residency program and have responsibility for:

- 4.2.c.1 Organization and leadership of the RAC that provides guidance for residency program conduct and related issues;

##### **Guidance:**

The RPD determines an appropriate schedule of residency advisory committee meetings to allow for effective oversight of the program.

The meetings can be a part of another routinely scheduled meeting.

##### **How it will be surveyed**

Review of documents relevant to the residency advisory committee (e.g., minutes, agenda, schedule, attendance log, and evidence of programmatic changes).

Discussion with RPD and preceptors.

- 4.2.c.2 Oversight of the progression of residents within the program and documentation of completed requirements;

##### **Guidance**

RPD may delegate responsibility for oversight to a qualified preceptor.

RPD has an established process for utilizing the resident’s development plan to monitor and document the residents’ progress towards achievement of the programs’ requirements for completion of the program.

##### **How it will be surveyed**

Review of a system the program has devised to track resident progression; such as review of residents’ development plans:

- for presence of quarterly updates
- to determine if adjustments to residents’ development plans appear appropriate for residents’ learning needs
- for dates and signatures on plans

- 4.2.c.3 Appointment of preceptors for the program;

- 4.2.c.3.1 RPDs, in cooperation with site coordinators and partnering organization when applicable, identify preceptors for the program.
- 4.2.c.3.2 RPDs develop and apply criteria consistent with those required by the Standard to qualify preceptors for the program.
- 4.2.c.3.3 RPDs appoint preceptors once qualified.
- 4.2.c.3.4 RPDs or designees create and implement an overall preceptor development program and oversee the creation of individual preceptor development plans.

**Guidance**

The term appointment refers to either initial or reappointment of preceptors. RPD can appoint or recommend appointment or reappointment of preceptors to the RAC or the appropriate pharmacy manager. Criteria for appointment and reappointment are documented. RPD uses appropriate methods to evaluate preceptors' skills (e.g., review of residents' evaluations of preceptors, peer review, preceptors' self-assessments, and performance reviews) and practice skills (e.g., skills required per job description, performance reviews) and helps preceptors improve as practitioners and preceptors. RPD may partially delegate this responsibility to the site coordinator or appropriate pharmacy manager for programs with multiple sites. Final approval of preceptors must be made by the RPD, RAC or other appropriate body of the sponsoring organization. Reappointment includes a review of each preceptor's qualifications and performance on a schedule determined by the RPD.

**How it will be surveyed**

Review of documentation of criteria for appointment and reappointment.  
 Discussion with RPD about the appointment/reappointment process.  
 Review of completed documentation used by the RPD to appoint and reappoint preceptors, as applicable.

- 4.2.c.4 Leadership of continuous residency program improvement in conjunction with the RAC; and,

**How it will be surveyed**

Discussion with RPD and review of residency advisory minutes, if applicable.

- 4.2.c.5 Collaboration with all partners of the program.

**Guidance**

The RPD and residency partners work together to ensure the success of the program.

**How it will be surveyed**

Discussion with RPD and residency partners.

4.3 Pharmacist Preceptors

**4.3.a Eligibility of Preceptors**

A pharmacist preceptor is a licensed pharmacist who:

- has completed an ASHP-accredited PGY1 residency and a minimum of one year of pharmacy practice experience in a community or ambulatory practice environment; or,

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

**Guidance**

**4.3.a is a critical factor (see Glossary for definition of “critical factor”).**

Preceptor’s pharmacy practice experience is relevant to the practice setting in which the learning experience is conducted.

4.3.b Qualifications of Preceptors

**Guidance**

When a list of examples is included in the guidance sections for 4.3.b.1 – 4.3.b.6, at least one of the examples is demonstrated within the last five years unless otherwise noted.

Duration of accreditation will be impacted only if greater than two-thirds of preceptors are not fully compliant with 4.3.b

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

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

**How it will be surveyed**

Review of resident’s evaluations of preceptors and their learning experiences.

Discussion with preceptors and residents.

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

**Guidance**

Preceptors provide specific, constructive criteria-based verbal feedback to residents during learning experiences and the end of learning experiences to assist residents in improving their performance. Formative written feedback to residents may be provided, if needed, during learning experiences and written summative feedback is provided at the end of learning experiences.

**How it will be surveyed**

Review of summative evaluations and other examples of documented feedback provided to the residents.

Discussion with residents and preceptors.

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

**Guidance**

**4.3.b.3 is a critical factor (see Glossary for definition of “critical factor”)**

Preceptors must have one of the following:

Examples:

- BPS certification
- Fellow at a state or national level organization
- Certificate of Completion from a state or nationally available program that relates to the area of practice in which they precept (e.g., Epic Willow certification, Six Sigma/LEAN Six Sigma certification, ISMP sponsored Medication Safety certificate, ASHP sponsored certificates). Health-system/local residency site based programs are excluded
  - Validated certification that results from an exam by the organization providing certification
  - Pharmacy related certification recognized by Council on Credentialing in Pharmacy (CCP) <http://www.pharmacycredentialing.org/Files/CertificationPrograms.pdf>
    - Other examples include: Certified Professional in Patient Safety (CPPS), Certified Diabetes Educator(CDE)
  - Exceptions to the list that do not meet this domain are ACLS, PALS and BLS
- Post-Graduate Fellowship in the advanced practice area or an advanced degree beyond entry level pharmacy degree (e.g., MBA, MHA)
- Formal recognition by peers as a model practitioner
  - Pharmacist of the year - recognized at state, city or institutional level where only one individual is recognized
  - Patient care, quality, or teaching excellence – recognition at organization level (not internal to pharmacy department only) for an initiative that resulted in positive outcomes for all patients that either was operational, clinical or educational in nature)
- Credentialing and privileging granted by the organization/practice/health system with ongoing process of evaluation and peer review
- Subject matter expertise as demonstrated by ten or more years of practice experience in the area of practice in which they precept

**How it will be surveyed**

- Review of academic and professional record form or PharmAcademic® review
- Review of credentialing and privileging policy as applicable
- Review of materials used in credentialing and privileging process

Duration of accreditation in this area will be impacted only if greater than two-thirds of preceptors are not fully compliant with 4.3.b.3

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

**Guidance**

**4.3.b.4 is a critical factor (see Glossary for definition of “critical factor”)**

Active practice is defined as maintaining regular and on-going responsibilities for the area where the pharmacist serves as a preceptor (may be part-time and/or at a remote location, but must be actively engaged).

Other aspects of active practice may include:

- contribution to the development of clinical or operational policies/guidelines or protocols in the practice site
- contribution to the creation/implementation of a new clinical service or service improvement initiative at the practice site
- active participation on a multi-disciplinary, pharmacy committee or work group responsible for patient care or practice improvement, etc.
- demonstrated leadership within the practice area

**How it will be surveyed:**

Discussion with preceptors, residents, and other health care practitioners.

Duration of accreditation in this area will be impacted only if greater than two-thirds of preceptors are not fully compliant with 4.3.b.4

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

**Guidance**

Preceptors maintain continuity of practice while residents are in their learning experiences.

A learning experience may use one or more preceptors.

**How it will be surveyed**

Discussion and review of residents' evaluations of preceptors and learning experiences.

**4.3.b.6 ongoing professionalism, including a personal commitment to advancing the profession.****Guidance:****4.3.b.6 is a critical factor (see Glossary for definition of "critical factor")**

Ongoing professionalism is demonstrated by completing at least 3 activities in the last 5 years.

Examples:

- Serving as a reviewer (e.g., contributed papers, grants, or manuscripts; reviewing/submitted comments on draft standards/guidelines for professional organizations)
- Presentation/poster/publication in professional forums
- Poster/presentation/project co-author for pharmacy students or residents at a professional meeting (local, state, or national)
- Active service, beyond membership, in professional organizations at the local, state, and/or national level (e.g., leadership role, committee membership, volunteer work)
- Active community service related to professional practice (e.g., Free Clinic, medical mission trips)
- Evaluator at regional residency conferences or other professional meetings
- Routine in-service presentations to pharmacy staff and other health care professionals
- Primary preceptor for pharmacy students
- Pharmacy technician educator
- Completion of a Teaching and Learning Program<sup>1</sup>
- Providing preceptor development topics at the site
- Professional consultation to other health care facilities or professional organizations (e.g., invited thought leader for an outside organization, mock, or practitioner surveyor)
- Contributing to health and wellness in the community and/or organization through active participation in health fairs, public events, employee wellness promotion/disease prevention activities, consumer education classes, etc.
- Publication of original research or review articles in peer-reviewed journals or chapters in textbooks
- Publication or presentation of case reports or clinical/scientific findings at local, regional, or national professional/scientific meetings or conferences

---

<sup>1</sup> Wright EA, Brown B, Gettig J, et al. Teaching and learning curriculum programs: Recommendations for postgraduate pharmacy experiences in education. Am J Health-Syst Pharm. 2014; 71:1292-302.

- Teaching of pharmacy students or other health care professionals (e.g., classroom, laboratory, inservice)
- Active involvement on committees within enterprise (e.g., work impacts more than one site across a health system)

**How it will be surveyed**

Review of Academic and Professional Record form or PharmAcademic® review.

Duration of accreditation in this area will be impacted only if greater than two-thirds of preceptors are not fully compliant with 4.3.b.6

4.3.c Preceptors’ Responsibilities

Preceptors serve as role models for learning experiences and they:

- 4.3.c.1 contribute to the success of residents and the program;
- 4.3.c.2 create, implement, and maintain learning experiences in accordance with Standard 3;
- 4.3.c.3 participate actively in the residency program’s continuous quality improvement processes;
- 4.3.c.4 demonstrate practice expertise, strive to continuously improve, and instruct the resident in learning experiences using established preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at appropriate levels required by the individual resident;
- 4.3.c.5 adhere to residency program and department policies pertaining to residents and services; and,
- 4.3.c.6 demonstrate commitment to advancing the residency program and pharmacy services.

**How it will be surveyed**

Review of relevant documents (e.g., learning experience descriptions, residents’ evaluations of preceptors and learning experiences).

Discussion with preceptors and residents.

4.3.d Preceptors-in-Training

- 4.3.d.1 Pharmacists who do not fully meet the qualifications for residency preceptors in sections 4.3.a, 4.3.b, and 4.3.c above are designated as preceptors-in-training.
  - 4.3.d.1.1 Each is assigned an advisor or coach who is a qualified preceptor.
  - 4.3.d.1.2 Each has a documented preceptor development plan to achieve qualifications to become a residency preceptor within two years.

**Guidance**

The plan developed for preceptors-in-training is documented and provides opportunities for preceptors-in-training to meet preceptor requirement within two years. The plan may be a component of an organizational performance review process.

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 documented plan for preceptor-in-training.  
Discussion with preceptors and RPD.

**4.4 Non-Pharmacist Preceptors**

- 4.4.a When non-pharmacists (e.g., physicians, physician assistants, certified nurse practitioners, administrators) are utilized as preceptors, the RPD and preceptors determine if the resident demonstrates independence as a practitioner to participate in the learning experience.
- 4.4.a.1 If independence as a pharmacist practitioner is required for the resident during the learning experience, the learning experience is scheduled after the RPD and preceptors agree that the resident is adequately prepared to perform at the required level.
- 4.4.a.2 If the learning experience is related to inter-professional training (e.g., acquiring skills and abilities to be taught by other health care professionals such as physical assessment and triage, or if working with individuals with expertise outside patient care), RPD and preceptors determine appropriate scheduling of learning experiences to maximize education and training of the resident.
- 4.4.a.3 The RPD, designee, or other pharmacist preceptors work closely with the non-pharmacist preceptor to select the educational goals and objectives for the learning experience.
- 4.4.a.4 At the end of each learning experience, non-pharmacist preceptors for the learning experience complete and document a criteria-based, summative evaluation of the resident's progress toward achievement of educational goals and objectives assigned to the learning experience.

**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.

Learning experience must have a qualified pharmacist preceptor to oversee the learning experience provided by a non-pharmacist preceptor and be a resource to both preceptor and resident.

Non-pharmacist preceptors do not need to meet preceptor requirements and don't have to fill out an Academic and Professional Record form. They do have to participate in the evaluation process (see above). Pharmacist preceptors can enter the information into PharmAcademic® based on input from non-pharmacist preceptors.

Readiness for independent practice in direct patient care is determined by the RPD and RAC and must be documented in the resident's development plan.

**How it will be surveyed**

Review of documentation of residents' readiness to work independently.

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

## 5.1 Requirements for a Sponsoring Organization

- 5.1.a All residency programs must have a sponsoring organization.
- 5.1.b The sponsoring organization maintains authority and responsibility for the quality of the residency program.
- 5.1.c The sponsoring organization ensures that the residency program meets residency accreditation requirements.
- 5.1.d Sponsoring organizations and all partnering organizations have signed agreement(s) that clearly define the responsibilities for all aspects of the residency program.
  - 5.1.d.1 A method of evaluation is in place to ensure that the purpose of the residency and the terms of the agreement are being met.
  - 5.1.d.2 A mechanism is established and documented for achieving consensus among partners on the evaluation and ranking of applicants for the residency.

### Guidance

**5.1 is the critical factor (see Glossary for definition of “critical factor”). Note any item listed in 5.1.a – 5.1.d may be used as a reason for citing 5.1.**

5.1 The organization designated as the sponsoring organization complies with the definition of “Sponsoring organization: in the glossary of the standard. The sponsoring organization establishes a signed agreement with partner organizations involved in the program. The agreement designates:

- The sponsoring organization
- Representation of the partner organization on the Residency Advisory Committee for the program
- The process for appointment of the residency program director
- Responsibilities of the RPD
- The responsibilities of the sponsoring organization and the partner organization(s)
- The financial terms of the agreement if the program is co-funded by the partner organization(s)
  - Authority for dismissal of residents
  - Identification and appointment of preceptors
  - The term of agreement follows conventions of the sponsoring organization in terms of how frequently the agreement needs to be reviewed, revised, or renewed.

### How it will be surveyed

Review and discussion of the agreement

## 5.2 Requirements for Practice Locations

- 5.2.a Practice locations compare the quality, safety, and financial viability of the patient care services provided at the location against national professional guidelines and Board of Pharmacy requirements to determine areas for improvement.
- 5.2.b **Practice locations have sought and accepted outside appraisal of facilities and patient care practices, when such appraisals are established and recognized. The external appraisal is conducted by a recognized organization appropriate to the individual practice.**



**Guidance****5.2.b is a critical factor (see Glossary for definition of “critical factor”).**

The sponsoring organization and all practice sites that offer or that participate in offering a pharmacy residency are accredited by applicable organizations [e.g., Board of Pharmacy, Center for Pharmacy Practice Accreditation (CPPA), URAC, PCAB (new name- ACHC), The Joint Commission (TJC), American Osteopathic Association (AOA)/Healthcare Facilities Accreditation Program (HFAP), National Committee for Quality Assurance (NCQA), Det Norske Veritas (DNV)]. A college or school of pharmacy that participates in offering a pharmacy residency is accredited by the Accreditation Council for Pharmacy Education (ACPE). Board of Pharmacy compliance. NABP (DME), other organizations that provide accreditation or review of patient.

**How it will be surveyed**

Review of the most recent documentation of recognition.

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

**Guidance**

Examples of evidence-based guidelines include

- MTM Core Elements
- APhA Immunization Guidelines
- APhA resources available at [www.pharmacist.com](http://www.pharmacist.com) ASHP resources available at [www.ashp.org](http://www.ashp.org)
- ACCP Professional resources <http://www.accp.com/about/links.aspx> AHRQ National Guideline Clearinghouse <https://www.guidelines.gov/>
- Standards from organizations such as NIOSH, OSHA, CLIA, EPA that apply to specific practice sites

**How it will be surveyed**

Observation of instances where professional standards should be followed.

Discussion with residents and pharmacy personnel.

### 5.3 Requirements for Program’s Organizational Structure

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

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

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

5.3.a.2 A PGY1 community-based multiple-site pharmacy residency is one in which two or more practice sites, or a sponsoring organization working in cooperation with one or more practice sites (e.g., independent community pharmacy, chain pharmacy, food chain pharmacy, outpatient clinic/facility physician practices, college of pharmacy, or health system) offer a pharmacy residency. A college of pharmacy (COP) is considered a practice location only if the COP has practice locations serving as a home base.

**5.3.a.2.1 For multiple-site programs, a site coordinator is appointed to manage and oversee the day-to-day operations of the**

**residency program at each home-base practice location by the RPD in cooperation with the practice location and partnering organization.**

- 5.3.a.2.2 RPD, site coordinators, and the partnering organization, when applicable, work together to appoint and develop pharmacy staff to become preceptors for the program.
- 5.3.a.2.3 A mechanism is documented for achieving consensus between partners on the evaluation and ranking of applicants for the residency.
- 5.3.a.2.4 For multiple-site programs, additional practice sites used for training an individual resident beyond the resident's home-base practice site meet the requirements established for pharmacy services in Standard 6.
- 5.3.a.2.5 Multiple-site residency programs are in compliance with the *ASHP Accreditation Policy for Multiple-Site Residency Programs*.

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

**5.3.b.1 Home-base practice location (site) meets the patient care services criteria under Standard 6.**

- 5.3.b.2 Multiple residents may be located within a single home-base practice location (site) if the level of services and patient care services are sufficient in diversity, variety, complexity, and quantity to educate and train multiple residents within the practice.

#### **Guidance**

**5.3.a.2.1, 5.3.b, and 5.3.b1 are critical factors (see Glossary for definition of "critical factor").**

Although a residency program may be offered/conducted by more than one organization, there may be only one sponsoring organization designation for a residency program. Sponsorship of a program is determined by the signature of the senior person on the application for accreditation (independent owner, appropriate executive/manager of a pharmacy chain, director of pharmacy for a hospital or ambulatory care organization, Dean/Department Chair of college of pharmacy, etc.).

The sponsoring organization has an appropriate organizational structure for the administration of the residency program (i.e., residency advisory committee) that ensures the organization has final authority for program decisions and program conformance with ASHP standards.

The program adheres to the definitions of a single-site residency or multiple-site residency as defined in the Glossary of Terms included in the PGY1 Community-Based Standard and ASHP Regulations on Accreditation of Pharmacy Residencies.

**A single-site residency:** a residency structure in which the organization assumes total responsibility for the residency program. In a single-site residency, a minimum of 40% of the resident's training program occurs at a home-base site within the organization. Residents may spend assigned time in short elective learning experiences outside the organization. (An example of a single-site residency would be a chain pharmacy where the resident is trained within a particular division of the chain and is assigned a minimum of 40% at one location designated as the home-base, up to 45% at other locations within the division, and spends 15% at a FQHC.) If more than 25% of the residency is conducted with an organization different from where the resident is home-based, the program will be considered a multiple-site residency.

**From the Regulations: Multiple-site residency.** A residency site structure in which multiple organizations or practice sites are involved in the residency program. Examples include programs in which: residents spend greater than 25% of the program away from the sponsoring organization/main site at another single site; or there are multiple residents in a program and they are home-based in separate sites (i.e., partner organizations).

For multiple-site residencies, there are two scenarios for which the definition applies:

Scenario 1: An independent pharmacy as the sponsoring organization with one resident. The resident spends 50% of the time at the pharmacy, 25% at a FQHC, and 25% at the health department.

Scenario 2: A college of pharmacy as the sponsoring organization with three residents: one resident home-based at a chain, one resident at an independent, and one resident at a charitable pharmacy.

In a multi-site residency, similar to a single-site residency, a minimum of 40% of the resident's training program occurs at a home-base site within at least one of the partner organizations.

As stated in the Guidance document for standard 3.3.b, the program may use up to four additional practice locations (sites) beyond the home-based organization to achieve the program's educational goals and objectives.

For multiple-site programs, additional practice sites beyond the resident's home-base must meet fully the requirements in Standard 6 for the services offered in their practice.

A site coordinator in a multi-site program adheres to the requirements for being a site coordinator in the ASHP Regulations on Accreditation of Pharmacy Residencies.

#### **How it will be surveyed**

Review of:

- program design to determine if a single-site or a multiple-site program.
- agreements between organizations.
- the responsibilities of the Residency Advisory Committee and site coordinator.
- service grid, interview with preceptors and residents, and tour of practice sites used in the program.
- review of services provided at each location used to train the resident

## **Standard 6: Pharmacy Practice**

### **6.1 Pharmacy Practice Structure and Management**

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

#### **Guidance**

A pharmacist has assigned responsibility for insuring compliance with requirements for the pharmacy as outlined in this Standard.

Examples include independent pharmacy owner, store manager in a chain, a pharmacist contracted to provide services in a physician office practice.

For dispensing pharmacies, the pharmacist-in-charge is registered with Board of Pharmacy as the pharmacist-in-charge.

**How it will be surveyed**

Review of:

- survey report of The Joint Commission or other accrediting body
- pharmacist’s state licensure/registration
- discussion with the pharmacist executive and his/her supervisor

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

6.1.b.1 mission statement;

**How it will be surveyed**

Review of the pharmacy mission statement of the sponsoring organization and sites used for the program (e.g., independent pharmacy, small chain, large chain, grocery chain with pharmacies, clinic with pharmacists, clinic with a pharmacy, etc.). In multiple-location programs, mission statements will only be reviewed for locations where the resident spends more than 25% of their time.

6.1.b.2 current policies and procedures that are readily available to staff participating in service provision;

**Guidance:**

Written (may be electronic) policies and procedures are organized in a manual or other document. Policies and procedures are present for controlled substance handling, drug distribution and dispensing, patient care services, medication errors, adverse drug reactions, use of samples, chart documentation and other policies that would be pertinent to the organization and sites used for the program.

**How it will be surveyed**

Review of written policies and procedures.

Discuss how residents and new staff are familiarized to policies and procedures.

6.1.b.3 descriptions of roles and responsibilities for all categories of pharmacy personnel, including residents;

**Guidance**

Job descriptions exist describing the roles and responsibilities for all categories of pharmacy personnel, including residents.

**How it will be surveyed**

Review examples of position descriptions including job description for residents.

**6.1.b.4 procedures to ensure that medication-use systems (ordering, dispensing, administration, and monitoring) are safe and effective; and,**

**Guidance**

**6.1.b.4 is a critical factor (see Glossary for definition of “critical factor”).**

Procedures are in place to ensure all aspects of the medication-use system are safe and effective. Quality assurance procedures for each step in the medication-use process are available.

**How it will be surveyed**

Review of:

- policies and procedures
- benchmarking procedures, if available
- quality assurance programs for all aspects of the medication-use system

Examples include procedures such as error rate reporting, adverse drug event reporting, and other examples of metrics used to improve safety.

**6.1.b.5 procedures to ensure that pharmacists' patient care services are safe, effective, and evidence-based.**

**Guidance**

**6.1.b.5 is a critical factor (see Glossary for definition of "critical factor").**

Policies and procedures include how pharmacists are involved proactively in patient care. This includes procedures for therapeutic regimen design and drug monitoring.

**How it will be surveyed**

Review of:

- scope of services.
- policies and procedures detailing scope of practice, safety, efficiency, and effectiveness of patient care.
- clinical process data that demonstrates that what pharmacists are doing is effective (e.g., percent of patients with hypertension, hyperlipidemia, diabetes, and other diseases achieving therapeutic goals).
- Current evidence-based guidelines used in policies and procedures. Examples include other benchmarking procedures and safety guidelines.

Discussion about how patient care services are proactively provided.

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

**Guidance**

**6.1.c is a critical factor (see Glossary for definition of "critical factor").**

Short-term is defined as one year.

Long-term is defined as > two years.

**How it will be surveyed**

Review of:

- short- and long-term goals for each pharmacy location used for greater than 25% of the resident's training.
- short- and long-term goals are incorporated into a strategic planning document for the organization (e.g., independent pharmacy, corporate based pharmacy, pharmacy department in a health care system, federally qualified community health center, etc.)

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

**Guidance**

Pharmacy personnel within the organization participate at some level in planning efforts that involve the design and delivery of patient care services and the provision of pharmaceutical care.

**How it will be surveyed**

Review of the following documents that are pertinent to the organization

- practice setting organizational chart
- pharmacy organizational chart
- list of organization’s committees and identification of pharmacy involvement
- strategic planning documents for the entire health care delivery system that pertain to the design and delivery of patient care services
- pharmacy strategic planning documents
- quality dashboard report
- survey report of an appropriate accrediting organization for the site or sites used for the program

Discussion with pharmacy leaders about their role in the planning of patient care services.

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

**Guidance**

**6.1.d. is a critical factor (see Glossary for definition of “critical factor”).**

Pharmacy leaders meet the regulations of all relevant government agencies and accrediting bodies.

**How it will be surveyed**

Review of:

- rules and regulations
- policies and procedures
- survey reports from The Joint Commission, CPPA, URAC, ACHC , and other accrediting organizations, as applicable
- inspection reports from the State Board of Pharmacy, as applicable
- Inspection reports from the State Board of Health, as applicable

Observation via tour of facilities.

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

**Guidance**

**6.1.e is a critical factor (see Glossary for definition of “critical factor”).**

See examples in 5.2 c above

Pharmacy leaders meet all applicable practice standards and guidelines, related to their practice

**How it will be surveyed**

Review of compliance with practice standards, or best practice/ guidance documents appropriate to the site or sites used for the program

Observation of instances where professional standards should be followed.

- Discussion with residents and pharmacy personnel.
- Observation via tour of facilities.

**6.2 Pharmacy Resources**

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

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

**Guidance**

**6.2.c is a critical factor (see Glossary for definition of “critical factor”).**

Pharmacists and residents have ready access to appropriate medical informatics.

Pharmacists are provided with sufficient time to provide the level of services required by patients served.

**How it will be surveyed**

Review patient care documentation.

Review space and workflow for the pharmacy sites used for the program.

Review available resources for medical informatics.

Discuss scheduling of pharmacists to allow provision of patient care services.

- 6.2.f has systems to support the connectivity and interoperability of information systems.

**6.3 Pharmacy Services**

- 6.3.a Pharmacy services, when applicable, extend to all areas of the practice internally and externally to the pharmacy in which medications for patients are prescribed, dispensed, administered, and monitored.
  - 6.3.a.1 Pharmacy services are integrated and provided collaboratively between internal and external areas of the practice.

**Guidance**

Pharmacy services extend to all patient care areas associated with the practice (i.e., inpatient, outpatient/ambulatory care clinics, diagnostic, emergency services) in which medications are prescribed, dispensed, administered, and monitored.

Patient care services provided by pharmacists offered outside the pharmacy are integrated with the services provided inside the dispensing pharmacy.

Pharmacy practitioners inside the dispensing pharmacy work collaboratively with pharmacy practitioners based outside the pharmacy.

### How it will be surveyed

Review of:

- services grid for community-based sites used by the program
- scope of services (what and where) for each site
- on-site tour of patient care areas
- pharmacy strategic planning documents
- survey report of CPPA, The Joint Commission or other accrediting organization
- pharmacy policies and procedures

Discussion of pharmacy services and patient care services provided by each practice location.

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

### Guidance

Services provided by pharmacy sites used for community-based residency programs meet quality expectations of the standard and are provided safely and efficiently. Medication management including comprehensive medication management and targeted medication intervention services with follow-up; health and wellness; immunizations; disease state management incorporating medication management; care transitions incorporating medication reconciliation and medication management; and patient-centered medication distribution, where pharmacists are responsible for the safe and effective procurement, preparation, distribution, and control of all medications used or administered throughout the practice, are provided following the JCPP Pharmacists' Patient Care Process (PPCP). Services are provided to a diverse range of patients in collaboration with health care teams.

The JCPP PPCP process includes the following steps for each of the required patient care services.

- Collect
- Assess
- Plan
- Implement
- Follow up: Monitor and Evaluate

Each of the components of the JCPP PPCP are incorporated in residents' training through the achievement of educational objectives and assigned learning activities associated with Competency Area R1: Patient Care, in the *Required Competency Areas, Goals, and Objectives for Postgraduate Year One (PGY1) Community-Based Pharmacy Residencies*.

The JCPP PPCP begins with the establishment of a patient-pharmacist relationship that supports engagement and communication with patients, families, and caregivers throughout the process. Collaboration, communication, and documentation are essential components of the JCPP PPCP and are incorporated in each step of the process. Policies and procedures for the provision of required patient care services are developed by the pharmacy administration and used by pharmacists and technicians involved in the provision of patient care services. Pharmacists follow and apply these steps to each of the required patient care services. Pharmacists who proficiently provide patient care services automatically use the PPCP in an efficient and safe manner. The amount of time needed to use the PPCP varies for each of the



required services of the Standard and will vary by the type of service and the needs of individual patients.

**6.3.b.1 medication management including comprehensive medication management and targeted medication intervention services with follow-up;**

**Guidance**

**6.3.b.1 is a critical factor (see Glossary for definition of “critical factor”).**

The use of the term comprehensive medication management in the context of the 2016 PGY1 Community-based Accreditation Standard refers to Medication Therapy Management (MTM). MTM is a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.

The core elements of a medication therapy management service in pharmacy practice includes the following:

- Medication therapy review (MTR)
- Personal medication record (PMR)
- Medication-related action plan (MAP)
- Intervention and/or referral (e.g., referral to another provider for evaluation and diagnosis, referral to a support service or program for disease state education/management, or referral to a monitoring program for high risk medications)
- Documentation and follow-up (e.g., collaboration and communication with prescribers and patients to resolve medication-related problems and scheduling follow-up, virtual or face-to-face, appointments with patients when needed to monitor the action plan)

For the purpose of the 2016 Standard, the expectation is that MTM Core Elements will be used when providing Comprehensive Medication Reviews (CMR) and Targeted Medication Reviews (TMR). Whether comprehensive or targeted, the individual patient’s medications are evaluated in the context of the patient as a whole, taking into consideration all of the patient’s conditions and medication therapies.<sup>2</sup>

Comprehensive medication reviews (CMRs) following the MTM Core Elements service model may be incorporated into a number of services including, but not limited to:

- Adherence and medication synchronization services
- Medicare Part D MTM annual reviews
- MTM platforms (e.g., Outcomes/PharmMD/Humana)
- Medication reconciliation with comprehensive medication reviews in clinic settings
- Medicare Annual Wellness Visits

Targeted medication reviews following the MTM Core Elements service model may be incorporated into a number of services including, but not limited to:

- Targeted interventions using MTM platforms
- Targeted interventions for populations such as
  - pneumococcal vaccinations for patients over the age of 55
  - statins for patients with diabetes
  - adherence to antipsychotics and antidepressants
  - use of controller medications in asthma
  - yearly TSH measurements for patients on thyroid replacement medications
  - depression screening in patients with chronic diseases

- interventions for poorly controlled patients with hypertension or diabetes
- monitoring programs for weight, SOB, edema for patients with CHF

Regardless of the type of practice at the home-base practice site (i.e., chain, independent, specialty, home-infusion, long term care, outpatient clinic, FQHC, physician's office, etc.), pharmacists at the home-base practice site complete CMRs for **at least three** chronic disease states including but not limited to <sup>3</sup>:

- Alzheimer disease
- Arthritis
- Chronic heart failure
- Diabetes
- Dyslipidemia
- End-stage renal disease
- Hypertension
- Mental health
- Respiratory disease

#### **How It will be surveyed**

- Documentation of CMRs and TMRs completed at the home- base practice site, 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
- Review of service grid for description and numbers of CMRs and TMRs completed at the home-base practice site
- Review of number of CMRs and TMRs that have documented follow-ups at the home-base practice site
- Discussion with preceptors and residents

### **6.3.b.2 health and wellness;**

#### **Guidance:**

**6.3.b.2 is a critical factor (see Glossary for definition of “critical factor”).**

Community pharmacies are strategically important settings that deliver services aimed at promoting health and creating wellness by preventing disease. Health and wellness services can be conducted with patients at the practice site as well as in the community. At least three health and wellness services should be offered and provided by pharmacists at the practice site or in the community.

Examples of services include, but are not limited to:

- 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

### **6.3.b.3 immunizations;**

**Guidance**

**6.3.b.3 is a critical factor (see Glossary for definition of “critical factor”).**

The home-based site must have policies and procedures that address the following immunization practices by pharmacists and/or pharmacy technicians:

- Pharmacists and/or pharmacy technicians conduct immunization histories from patients and maintain immunization histories in patient medication profiles;
- Pharmacists and/or pharmacy technicians screen patients for needed immunizations;
- Pharmacists administer immunizations to patients;
- Pharmacists and/or technicians safely store vaccines;
- Pharmacists manage and document adverse drug reactions from immunizations;
- Forms used by pharmacists and technicians; and,
- Pharmacists collaborate with other providers to assure that patients’ records of immunization are accurate and maintained.

The home-based site provides at least three types of immunizations which may include, but are not limited to:

- Influenza
- Tetanus
- Diphtheria, Pertussis (Tdap)
- Diphtheria (Td)
- Varicella (chickenpox)
- Human papillomavirus (HPV, 3 doses)
- Zoster (shingles)
- Measles, mumps, and rubella (MMR)
- Pneumococcal disease
- Hepatitis A
- Hepatitis B

**How it will be surveyed**

- Review the home-based service grid to determine immunizations types and the number of immunizations provided by type.
- Review immunization policies and procedures

**6.3.b.4 disease state management incorporating medication management; and**

**Guidance**

**6.3.b.4 is a critical factor (see Glossary for definition of “critical factor”).**

Disease state management performed by pharmacists includes collaboration with patients and/or caregivers and members of the healthcare team to optimize patient outcomes through the use of evidence-based medicine to identify, prevent, and resolve medication-related problems and improve quality of life through achievement of therapeutic goals.

Disease state management is required in all community-based practice settings. For example, services may be provided by pharmacists:

- practicing within the same location as other members of the interdisciplinary team by using documented procedures or protocols, collaborative practice agreements, or prescriptive authority. Examples of these practice settings may include, but are not limited to Federally Qualified Healthcare Centers (FQHCs), hospital outpatient pharmacies and clinics, or physician group practices with a pharmacy within the medical office or building.
- practicing in a different location from other members of the interdisciplinary team, where they partner with one physician or a physician group practice by using documented procedures or protocols, collaborative practice agreements, or prescriptive authority. Initial disease state management services may begin with providing care to patients for one physician. As services expand, partnerships with other physicians may develop with provision of care expanding to additional patients and a variety of disease states. Examples of these practice settings include, but are not limited to independent, chain, and specialty pharmacies.

**Role of the Pharmacist in Disease State Management, incorporating the JCPP PPCP, includes:**

**\* Collect**

- Gather all the pertinent and relevant patient information (objective and subjective) necessary to manage the patient.
- Review medical records, including pertinent laboratory data.
- Interview patients and/or caregivers.

**\* Assess**

- Assess current status of disease state(s).
- Analyze patient information obtained via patient interview and review of medical records.

**\* Plan**

- Establish patient-specific goals (in **collaboration** with the multidisciplinary healthcare team)
- Develop care plan(s), including non-pharmacologic and pharmacologic treatment (i.e., **initiate, modify, and discontinue therapy**).

**\* Implement**

- Educate patients and/or caregivers regarding disease state(s).
- Educate patients and/or caregivers regarding care plan.
- Document care plan in the permanent medical record.
  - Include communication of care plan to multidisciplinary healthcare team.

**\* Follow-up: Monitor and Evaluate**

- Monitor disease state(s) and progress towards established therapeutic goals.
- Order relevant and pertinent laboratory tests, as needed.
- Schedule follow-up visit(s) with pharmacist or refer patients to specialist or other healthcare provider, as necessary.

Regardless of the type of practice at the home-base practice site (i.e., chain, specialty, home-infusion, and independent), disease state management services include **at least three** chronic disease states. Examples of chronic disease states include but are not limited to<sup>5</sup>:

- Alzheimer disease
- Arthritis

- Chronic heart failure
- Diabetes
- Dyslipidemia
- End-stage renal disease
- Hypertension
- Mental health
- Respiratory disease

**How will be surveyed**

- Discuss incorporation of the JCPP PPCP in the provision of disease state management during patient encounters
- Verify disease state management services at the home-base site include at least three chronic disease states (see examples in Guidance above)
- Review disease state management data from the service grid

6.3.b.5 care transitions with incorporated medication reconciliation and medication management.

**Guidance**

Care transitions is a time-limited service to ensure healthcare continuity and avoid poor health outcomes while a patient is transitioning from one setting of care to another.<sup>1</sup> Transition of care is the movement of a patient from one care setting to another, which can occur within settings, between settings, across the continuum of health states and between providers.<sup>2</sup>

Medication reconciliation, medication therapy management, and patient education form the core of pharmacist activities that may improve the care provided during transitions.

Home-base practice sites provide the following services for patients undergoing care transition(s):

- 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.

The community-based pharmacy may partner with hospitals, nursing homes, and/or insurers to identify eligible patients for transition of care (TOC) services. Services should be interdisciplinary and may include partnerships with ambulatory providers and nurses as appropriate.

6.3.c The patient-centered dispensing system includes the following components:

**6.3.c.1 a system where pharmacists are responsible for the safe and effective procurement, preparation, distribution, and control of all medications used or administered throughout the practice;**

**Guidance:**

**6.3.b.1, b.2, b.3, b.4 and 6.3.c.1 are critical factors (see Glossary for definition of “critical factor”)**

Future updates of the guidance document will include more guidance on services (6.3b.1-5)

The home base location where the resident spends a minimum of 40% of their time, provides all the patient care services listed under 6.3.b. The location where the patient-centered dispensing learning experience is taught, meets all the requirements listed under 6.3.c.

**How it will be surveyed**

Review of each practice site used for the program:

- services grid
- job descriptions
- benchmark/outcomes/dashboard data or other information for monitoring the quality and quantity of pharmacy services provided by a pharmacy site
- survey report of an accrediting or other organization reviewing patient care services
- pharmacy personnel work schedules
- written pharmacy policies and procedures
- on-site tour of patient care areas and other observations

6.3.c.2 a system fostering accountability and optimization of safe medication-use system technologies;

**6.3.c.3 routine patient counseling and education services on medication initiation, with any change to medication therapy, for high-risk medications and high-risk patients; and,**

6.3.c.4 evidence-based targeted interventions integrated into the patient-centered dispensing process.

**Guidance:**

**6.3.c.3 is a critical factor (see Glossary for definition of “critical factor”).**

Preceptors will be able to describe and provide examples of how patient counseling and education services are provided.

**How it will be surveyed?**

Discussion and review of counseling and education services examples.

**6.4 Pharmacists’ Roles/Responsibilities**

Pharmacists providing professional services at the practice will:

6.4.a manage selection, procurement, storage, and dispensing of medications used within the organization;

**6.4.b prospectively review, evaluate, and assess the appropriateness and safety of medication prescriptions/orders;**

6.4.c assist patients with self-care decisions;

6.4.d administer medications based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;

6.4.e manage adverse drug event monitoring, resolution, reporting, and prevention programs;

6.4.f develop and define protocols for the delivery of patient care services;

- 6.4.g follow the Joint Commission of Pharmacy Practitioners (JCPP) Pharmacists' Patient Care Process using the principles of evidence-based practice;
- 6.4.h identify and take responsibility for resolution of drug therapy problems;
- 6.4.i perform physical assessments and conduct, order, and interpret laboratory tests based on collaborative practice agreements or other treatment protocols consistent with the law, regulations, and practice policies and procedures;
- 6.4.j participate in initiating, modifying, and discontinuing drug therapy, based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures;
- 6.4.k proactively provide education and counseling to patients regarding medications and related products;
- 6.4.l document patient care in the patient's health care record;
- 6.4.m communicate with patients and families as appropriate to address and resolve potential barriers to safe and effective medication use (e.g., literacy, access, language needs);
- 6.4.n collaborate, document, and communicate with physicians, other pharmacists, patients, and other health care professionals as a member of an interprofessional team in the provision of safe, effective, and coordinated patient-centered care;
- 6.4.o provide educational programs about medications, medication therapy, health, and other related matters to patients, caregivers, and health care providers; and,
- 6.4.p participate in projects and activities relating to improving population health.

<p><b>Guidance</b>  <b>6.4.b, 6.4.g, 6.4.h, 6.4.j, 6.4.k, 6.4.l, 6.4.m and 6.4.n are critical factors (see Glossary for definition of 'critical factor')</b></p>
<p><b>How it will be surveyed</b>  Review of services provided.</p>

6.5 Continuous Quality Improvement

- 6.5.a Practice personnel engage in an ongoing process to assess the quality of pharmacy services.

<p><b>Guidance</b>  <b>6.5.a is a critical factor (see Glossary for definition of "critical factor").</b>  This includes routine quality improvement for drug distribution, clinical services, and appropriate patient care documentation.</p>
<p><b>How it will be surveyed</b>  Documentation of assessment of quality of services.  Minutes of meetings where error rates, patient data outcomes and other quality measures are discussed.  Review of documentation of improvement initiatives and resulting changes implemented, where necessary.  Review of patient care documentation.  Discussion with appropriate practice site staff.</p>

- 6.5.a.1 The practice has procedures to document, track, evaluate, and report patient care outcomes data.

**Guidance**

This focuses on the presence of procedures, as opposed to the quality of the procedures, which would be reviewed elsewhere (See 6.1.d.5).

Documentation of pharmacist-provided patient care outcomes over time demonstrating improvement of specific quality indicators (e.g., A1C, Lipid levels, BP).

The pharmacy shall have an ongoing process for consistent documentation of the patient care services provided by pharmacists and patient outcomes from medication therapy MTM, health and wellness, immunizations, disease management services, care transitions, and other patient care services provided in the practice).

**How it will be surveyed**

Review of examples of patient care outcomes data.

Discussion (e.g., How do you document patient care outcomes data?).

Examples include quality indicators for patient care services and core measures for the practice site.

**6.5.b Practice personnel develop and implement pharmacy services improvement initiatives in response to assessment results.**

**Guidance**

**6.5.b is a critical factor (see Glossary for definition of “critical factor”).**

**How it will be surveyed**

Review of documentation of improvement initiatives and resulting changes implemented, where necessary.

**6.5.c Practice assessment and improvement processes routinely include assessing and developing skills of the practice’s staff.**

**Guidance**

Consider providing education to all staff 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 improvement initiatives for pharmacy staff skill improvement and resulting changes implemented, when necessary.

Discussion with pharmacy staff.

## Glossary

**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.

**Note:** The reader is referred to the **Glossary of Definitions** at the conclusion of the *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs* for a complete list.



## References

1. ASHP regulations on accreditation of pharmacy residencies; American Society of Health-System Pharmacists; 2010. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: <http://www.ashp.org>. Available from Internet. Accessed 2016 February 3.
2. Pharmacy specific duty hour requirements for the ASHP accreditation standards for pharmacy residencies; American Society of Health-System Pharmacists; 2012. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: <http://www.ashp.org>. Available from Internet. Accessed 2016 February 3.
3. Rules for the ASHP pharmacy resident matching program; American Society of Health-System Pharmacists; 2006. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: <http://www.ashp.org>. Available from Internet. Accessed 2016 February 3.
4. Required and elective educational competency areas, goals, and objectives for the postgraduate year one (PGY1) community-based pharmacy residency standard. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: <http://www.ashp.org>. Availability to be determined.
5. ASHP accreditation policy for multiple-site residency programs. American Society of Health-System Pharmacists Home Page [resource on World Wide Web]. URL: <http://www.ashp.org>. Available from Internet. Accessed 2016 February 3.

Approved by the ASHP Commission on Credentialing January 15, 2016. Approved by the ASHP Board of Directors January 22, 2016. Approved by the APhA Board of Trustees January 22, 2016.

Developed by APhA in partnership with the ASHP Commission on Credentialing, ASHP staff, and the APhA PGY1 Community Accreditation Standard Taskforce. The APhA PGY1 Community Accreditation Standard Taskforce was directed by James Owen, APhA Vice President of Practice and Science Affairs, and was facilitated by Marialice Bennett, Former APhA President and current ASHP Lead Surveyor. Members include Stephanie Barrus, Anne Burns, Rebecca Cupp, Laurie Fleming, Jean-Venable “Kelly” Goode, William Grise, Cherokee Layson-Wolf, William Miller, Janelle Ruisinger, Jeri Sias, Judy Sommers-Hanson, Monet Stanford, Akilah Strawder, and Eric Grace. The contributions and significant commitment of these individuals in the development of this Standard is gratefully acknowledged and sincerely appreciated.

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

Copyright © 2021, American Society of Health-System Pharmacists, Inc. All rights reserved.

**Guidance revisions approved by the ASHP Commission on Credentialing on March 5, 2021 and are effective immediately.**

**Published to ASHP website: June 2021**