

GUIDANCE DOCUMENT FOR THE ASHP ACCREDITATION STANDARD FOR POSTGRADUATE YEAR ONE (PGY1) MANAGED CARE PHARMACY RESIDENCY PROGRAMS

Updated April 2018

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.

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.

**Prepared jointly by the American Society of Health-System Pharmacists and the
Academy of Managed Care Pharmacy**

Introduction

Purpose of this Standard: the *ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Managed Care Residency Programs* (hereinafter the Standard) establishes criteria for training pharmacists to achieve professional competence in the delivery of patient-centered care and pharmacy services in managed care settings. A PGY1 pharmacy residency is a prerequisite for postgraduate year two (PGY2) pharmacy residencies.

PGY1 Managed Care Program Purpose: PGY1 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and outcomes to develop managed care pharmacist clinicians with diverse patient care, leadership and education skills who are eligible for board certification and postgraduate year two (PGY2) pharmacy residency training. A managed care residency will provide systematic training of pharmacists to achieve professional competence in the delivery of patient care and managed care pharmacy practice.

Application of the Standard: the requirements serve as the basis for evaluating a PGY1 managed care pharmacy residency program for accreditation.

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.

The Standard describes the criteria used in evaluation of practice sites that apply for accreditation. The accreditation program is conducted under the authority of the ASHP Board of Directors and is supported through a formal partnership with the Academy of Managed Care Pharmacy (AMCP). The *ASHP Regulations on Accreditation of Pharmacy Residencies*¹ describes the policies governing the accreditation program and procedures for seeking accreditation.

Overview of the Standards for PGY1 Managed Care Pharmacy Residencies

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

Standard 1: Requirements and Selection of Residents

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

Standard 2: Responsibilities of the Program to the Resident

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

Standard 3: Design and Conduct of the Residency Program

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

Standard 4: Requirements of the Residency Program Director and Preceptors

The residency program director (RPD) and preceptors are critical to the residency program's success and effectiveness. Their qualifications and skills are crucial. Therefore, the residency program director and 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 of the Sponsoring Organization and Practice Site(s) Conducting 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 Environment

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 and programs to improve patient care outcomes. Pharmacy's role in providing effective leadership, quality improvement efforts, appropriate organization, staffing, 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 programs, and should motivate the profession to continually improve patient care outcomes.

Standard 1: Requirements and Selection of Residents

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

Guidance

This procedure may appear 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.

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 must be used by all involved in the evaluation and ranking of applicants.

How it will be surveyed

Review of procedure and criteria

Discussion with preceptors/RAC members.

1.3 Applicants to pharmacy residencies must be 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 Equivalency 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 and the documented procedure described above in Standard 1.1.

1.4 Applicants to pharmacy residencies must be 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 90 days of the start date of the residency must be addressed in written policy of the residency program.

Guidance

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

The policy can appear in the residency manual or other readily available pharmacy department documents.

Program documents how resident's plan will be modified if the resident isn't licensed 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.

1.6 Requirements for successful completion and expectations of the residency program must be documented and provided to applicants invited to interview, including policies for professional, family, and sick leaves and the consequences of any such leave on residents' ability to complete the residency program and for dismissal from the residency program.

1.6.a These policies must be reviewed with residents and be consistent with the organization's human resources policies.

Guidance

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 or on the interview date.

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

The following policies and procedures are documented:

- Dismissal policy. Dismissal or disciplinary policy must address consequences of failure to progress
- Licensure
- Moonlighting
- Duty hours
- Tracking of duty hours and moonlighting
- Professional, family, sick and extended leave. Consequences of professional, family, sick and extended leave on residents' ability to complete the residency program must include whether the leave will result in dismissal from the program or if the program allows for extension of the program in order to allow residents to complete all program requirements, including the requirement for a minimum of twelve months of training.

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

- Achievement of the program's educational goals and objectives (e.g., designate % achieved, specify objectives that must be achieved, or as defined by the program)
- List of required duties and responsibilities
- List of products requiring completion
- List of required presentations

The list of requirements for successful completion must match the list used to document resident's completion of program requirements (see guidance for 2.7a).

Policies and procedures must be consistent with human resources policies and procedures, and must be consistent among themselves and what is provided to the resident.

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 If a resident takes a leave of absence, time away is not counted towards the 12 months.
How it will be surveyed Review of: <ul style="list-style-type: none">• residents’ schedules.• extended leave policy. Discussion with RPD and residents about how extended leaves are managed, overview of resident’s schedule, or documentation of extension of the resident’s program when an extended leave has occurred.

2.2 Programs must comply with the **ASHP Duty-Hour Requirements for Pharmacy Residencies**.

Guidance Programs provide a link or documentation to residents of the <i>ASHP Duty-Hour Requirements for Pharmacy Residencies</i> policy published on the ASHP website. Programs document in program materials whether or not moonlighting is allowed. Programs have a process for monitoring compliance with the <i>ASHP Duty-Hour Requirements for Pharmacy Residencies</i> policy. 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: <ul style="list-style-type: none">• 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 must adhere to the **Rules for the ASHP Pharmacy Resident Matching Program (Match)**, unless exempted by the ASHP Commission on Credentialing.

Guidance The following are approved exemptions: <ul style="list-style-type: none">• 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 st . 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 residency program director (RPD) must provide 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, criminal record check) and other relevant information (e.g., benefits, stipend) must be provided.
- 2.4.b Acceptance by residents of these terms and conditions, requirements for successful completion, and expectations of the residency program must be documented prior to the beginning of the residency.

Guidance

Residents accept and sign the offer letter (including pre-employment requirements) and signify that they understand the list of requirements and expectations (as listed in standard 1.6 guidance) of the residency program prior to the beginning of the residency. This may be accomplished within the offer letter (if possible) or within a separate document created by the program. Transmittal and execution of a contract or agreement constitutes acceptance, and would be acceptable in place of a signed offer letter.

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 must provide 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 is a sufficient number of preceptors available to facilitate achievement of the competencies, goals, and objectives and to guide (model, coach, facilitate) residents for each learning experience. Preceptors assigned as the primary preceptor for a learning experience are qualified to practice in the area of 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 must provide residents an area in which to work, references, an appropriate level of relevant technology (e.g., clinical information systems, workstations, databases), access to extramural educational opportunities (e.g., a pharmacy association meeting, a regional residency conference), 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 meet requirements of the program (e.g., travel to professional meeting, registration for meetings, statistical support for projects, poster production).

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 will award a certificate of residency only to those who complete the program’s requirements.

2.7.a Completion of the program's requirements must be documented.

Guidance

2.7 and 2.7.a. are critical factors (see Glossary for definition of "critical factor").

See Standard 2.4b for guidance on "requirements for completion."

Programs have a list of requirements and expectations for completion of the residency program

Requirements for successful completion include at minimum:

- Successful completion of all required 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 products requiring completion, and,
- List of required presentations.

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 certificate provided to residents who complete the program's requirements must be issued in accordance with the provisions of the **ASHP Regulations on Accreditation of Pharmacy Residencies¹**, and signed by the RPD and the chief executive officer of the organization or an appropriate executive with ultimate authority over the residency.

2.8.a Reference must be made in the certificate of the residency that the program is accredited by ASHP in partnership with AMCP.

Guidance

For programs in candidate status, certificates issued to residents indicate that the program is in candidate status. Once the program achieves accredited status, new certificates are issued to these 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 logos are encouraged and, if used, follow all applicable rules and the ASHP Style Guide as published by ASHP on the accreditation website (see Residency Accreditation Tools: Program Logo). PGY1 programs must follow ASHP Regulations on Residency Accreditation regarding naming of their program (see additional guidance under Standard 2.9).

How it will be surveyed

Review of certificate for signatures and wording.

2.9 The RPD must maintain 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* (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). Programs must utilize the PharmAcademic close-out procedures to notify ASHP regarding the completion/non-completion of enrolled residents.

How it will be surveyed

All elements of the regulations will be reviewed to determine compliance.

Review of Application Procedures

Review of Pharm Academic

May review records of past residents to determine if they have been maintained for the appropriate length of time as specified in the regulations.

Regulations: “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 six 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.”

Standard 3: Design and Conduct of the Residency Program

3.1 Residency Purpose and Description

The residency program must be 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.

PGY1 Managed Care Pharmacy Residency Program Purpose: To build upon the Doctor of Pharmacy (Pharm.D.) education and outcomes to develop pharmacist clinicians with diverse patient care, leadership and education skills who are eligible for board certification and postgraduate year two (PGY2) pharmacy residency training. A managed care pharmacy residency will provide systematic training of pharmacists to achieve professional competence in the delivery of patient care and managed care pharmacy practice.

Guidance

The program uses the required PGY1 Managed Care Pharmacy Residency purpose statement in program materials.

The program’s design is consistent with the program purpose statement.

The program may develop a **SUPPLEMENTAL** brief description of their program that aligns with the purpose statement of a PGY1 Managed Care Pharmacy residency and elaborates on any unique aspects

of their program. The description should not include any modification the the PGY1 Managed Care Pharmacy residency purpose statement that is used for all residency programs.

How it will be surveyed

Review of purpose statement, description (if applicable), and the design of the program.

3.2 Competency Areas, Educational Goals and Objectives

3.2.a The program’s educational goals and objectives must support achievement of the residency’s purpose.

3.2.b The following competency areas and all associated educational goals and objectives⁴ are required by the Standard and must be included in the program’s design:

- (1) patient care;
- (2) advancing practice and improving patient care;
- (3) leadership and management; and,
- (4) teaching, education, and dissemination of knowledge.

Guidance

3.2.b.(1)–(4) are critical factors (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 required learning experiences.

All required goals and objectives are assigned to be taught and evaluated at least once in required learning experiences. Some goals and 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
- Home Care
- Teaching and Learning
- Specialty Pharmacy
- Health, and Wellness

Programs may add educational goals as long as 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 patient care activities. (See 3.3.a.6)

Elective competency area(s), goal(s), and objective(s) selected for specific residents are documented

and managed through the resident's development plan.

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.

Review of the specific resident's development plan for inclusion of elective competency areas, goals and objectives, as applicable.

Resident Learning

3.3.a Program Structure

3.3.a.(1) A written description of the structure of the program must be documented formally.

3.3.a.(1)(a) The description must include required learning experiences and the length of time for each experience.

3.3.a.(1)(b) Elective experiences must also be listed in the program's design.

3.3.a.(2) The program's structure must facilitate achievement of the program's educational goals and objectives.

3.3.a.(3) The structure must permit residents to gain experience and sufficient practice with diverse patient populations, a variety of disease states, and a range of patient problems.

3.3.a.(4) Residency programs must ensure that the program's learning experiences meet the above requirements for diversity, variety, and complexity.

3.3.a.(5) No more than one-third of the twelve-month PGY1 managed care pharmacy residency program may deal with a specific patient disease state and population (e.g., diabetes, cardiovascular disease, multiple sclerosis, hepatitis C, inflammatory diseases).

3.3.a.(6) Residents must spend two thirds or more of the program in patient care activities.

Guidance

3.3.a.(2)-(4) are critical factors (see Glossary for definition of "critical factor").

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).

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

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

Patient Care activities provided by Pharmacists:

Activities performed by pharmacists with the intent of contributing to positive pharmacotherapeutic and health outcomes of individual patients. Care is in collaboration and communication with other members of the health care team with responsibilities for the individual patient, 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 (but are not limited to this list):

- Completing comprehensive (i.e., thorough review of medication profiles) or targeted (i.e., clinical

intervention program) medication reviews..

- Performing drug therapy management including, for example, high risk drugs, high risk patients, (e.g., anticoagulation management, renal dosing, pharmacokinetics) and pharmacogenomics and participating in disease state management services (e.g., case management or care management).
- Collecting and organizing patient-specific information needed by the pharmacist to improve health status and/or 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 (medication action 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 measures, 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.
- Performing or participating in medication reconciliation.
- 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.
- Patient-centered preparation and dispensing of medications for individual patients, including ensuring patient access to their medications.
- Critical appraisal and analysis of appropriate literature, evidence-based guidelines, utilization data, population data, compendia, models, in order to develop formulary, utilization management criteria, and clinical intervention programs and strategies which are applied to individual patients (e.g., development of treatment guidelines and prior authorization criteria, care pathways, order sets).
- Prospective medication evaluation (e.g., evaluating and interpreting diagnostic information, utilization management (add examples), prior authorization).
- Evaluation of need for, and appropriateness of, drug therapy.

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.b Orientation

Residency program directors must orient 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 (see standard 3.4).
- residency manual (if applicable).
- residency policies, terms and conditions, e.g., requirements for completion, moonlighting, duty hours, dismissal.

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.c Learning Experiences

3.3.c.(1) Learning experience descriptions must be documented and include:

- 3.3.c.(1)(a) a general description, including the practice area and the roles of pharmacists in the practice area;
- 3.3.c.(1)(b) expectations of residents;
- 3.3.c.(1)(c) educational goals and objectives assigned to the learning experience;
- 3.3.c.(1)(d) for each objective, a list of learning activities that will its facilitate achievement; and,
- 3.3.c.(1)(e) a description of evaluations that must be completed by preceptors and residents.

Guidance

3.3.c.(1)(c)-(d) are critical factors (see Glossary for definition of “critical factor”).

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 describe how residents will progress and the expectation for their skill development over time and in any repeated learning experiences. Residents progress over the course of the residency to be more efficient, effective, and able to work independently in providing patient care. If a successfully completed learning experience is repeated, the preceptor should elevate the expectations for the resident during the repeated experience.

Changes in expectations should be documented at the start of the repeated experience or in multiple learning experience descriptions (e.g., Patient Care I, Patient Care II, etc.)

Learning activities are developed at the cognitive learning level (Bloom’s Taxonomy) associated with the objective. Learn more at:

<http://www.ashpmedia.org/softchalknewbloomlearningtaxonomiesandlevels-2015-Jan/index.html>

Resource: template for learning experience descriptions on ASHP website

How it will be surveyed

Review of learning experience descriptions.

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

- 3.3.c.(2) Preceptors must orient residents to their learning experience using 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.c.(3) During learning experiences, preceptors will use the four preceptor roles as needed based on residents' needs.

Guidance Preceptors assume the appropriate preceptor roles based on the time of the year and residents' progression. <ul style="list-style-type: none"> • 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.

3.3.c.(4) Residents must progress over the course of the residency to be more efficient, effective, and able to work independently in providing patient care.

Guidance Preceptors provide sufficient opportunities and repetitions for residents to achieve the program's educational goals and objectives and progress towards independence. Residents make satisfactory progress in the program's competency areas.
How it will be surveyed Review of evaluations of residents and their development plans to determine if they are demonstrating progression to independence over time. Discussion with residents and preceptors.

3.4 Evaluation

The extent of residents' progression toward achievement of the program's required educational goals and objectives must be evaluated.

3.4.a Initial assessment

3.4.a.(1) At the beginning of the residency, the RPD in conjunction with preceptors, must assess each resident's entering knowledge and skills related to the educational goals and objectives.

3.4.a.(2) The results of residents' initial assessments must be documented by the program director or designee in each resident's development plan by the end of the orientation period and taken into consideration when determining residents' learning experiences, learning activities, evaluations, and other changes to the program's overall plan.

3.4.b Formative (on-going, regular) assessment

3.4.b.(1) Preceptors must provide on-going feedback to residents about how they are progressing and how they can improve that is frequent, immediate, specific, and constructive.

- 3.4.b.(2) Preceptors must make appropriate adjustments to residents' learning activities in response to information obtained through day-to-day informal observations, interactions, and assessments.

Guidance

3.4.a.(2) and 3.4.b.(1) are critical factors (see Glossary for definition of "critical factor").

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

Feedback should be qualitative and criteria based.

Frequency of ongoing feedback varies based on residents' progress and time of the year.

Some 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.

Oral formative feedback is required by the Standard; to supplement this, documentation of feedback may be necessary for residents who are not progressing satisfactorily.

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 learning experience descriptions.

Discussion with residents and preceptors.

3.4.c Summative evaluation

- 3.4.c.(1) At the end of each learning experience, residents must receive, and discuss with preceptors, verbal and written assessment on the extent of their progress toward achievement of assigned educational goals and objectives, with reference to specific criteria.

Guidance

3.4.c.(1) is a critical factor (see Glossary for definition of "critical factor").

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

- are specific and actionable.
- use criteria related to specific educational objectives.
- recognize residents' skill development.
- focus on how residents' may improve their performance.

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 improve 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.

Determine quality of summative evaluations by:

- review of explanation of ratings (e.g., achieved, achieved for the residency, satisfactory

- progress, needs improvement).
- review of criteria-based feedback in written summative evaluations.

3.4.c.(2) For learning experiences greater than or equal to 12 weeks in length, a documented summative evaluation must be completed at least every three months.

3.4.c.(3) If more than one preceptor is assigned to a learning experience, all preceptors must provide input into residents' evaluations.

Guidance

If multiple preceptors, one preceptor should be identified as the primary preceptor. Programs determine if they will have each preceptor provide input into PharmAcademic® or if all preceptors will provide input to the primary preceptor who will document the joint evaluation. The primary preceptor seeks consensus of preceptors to determine final ratings and co-sign evaluations. Co-preceptors are encouraged to provide documentation in residents' written evaluations.

How it will be surveyed

Review of summative evaluations.
Discussion with preceptors and/or residents.

3.4.c.(4) For preceptors-in-training, both the preceptor-in-training and the preceptor advisor/coach must sign evaluations.

3.4.c.(5) Residents must complete and discuss at least one evaluation of each preceptor at the end of the learning experience.

Guidance

All preceptors with significant exposure to working with residents in a learning experience are evaluated by residents at least once.
Evaluations are completed by the due date or within 7 days.

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 learning experience evaluation dates in PharmAcademic® reports or other reports if PharmAcademic® is not used.

3.4.c.(6) Residents must complete and discuss an evaluation of each learning experience at the end of the learning experience.

Guidance

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

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.

3.4.d Residents' development plans

3.4.d.(1) Each resident must have a resident development plan documented by the RPD or designee.

General Guidance

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.

1st, 2nd, and 3rd quarter updates

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

Adjustments are made based upon review of residents' performance 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.

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.

How it will be surveyed

Review of resident development plans:

- 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.d.(2) On a quarterly basis, the RPD or designee must assess residents' progress and determine if the development plan needs to be adjusted.

3.4.d.(3) The development plan and any adjustments must be documented and shared with all preceptors.

Guidance

3.4.d.(2) is a critical factor (see Glossary for definition of "critical factor").

See guidance under 3.4.d.(1)

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 managed care 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).
- review of end of year end written feedback by residents on the strengths and areas for improvement of the residency program
- information obtained from input from involved stakeholders/partners (e.g., college of pharmacy and pharmacy management)

For 3.5.c.(1), information tracked includes initial employment, and may include changes in employment, board certification, surveys of past graduates, or other applicable information. May be tracked in PharmAcademic®.

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.

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 must have a single residency program director (RPD) who must be a pharmacist from a practice site involved in the program or from the sponsoring organization.
- 4.1.b The RPD must establish and chair a residency advisory committee (RAC) specific to that program.

Guidance

The intent of 4.1b is to ensure that department leadership, program leadership and preceptors are engaged in design and oversight of individual residency programs.

In organizations with multiple programs, it may be appropriate to have one organizational RAC. This is an acceptable alternative to having a RAC for each program, if all RPDs are members, there is appropriate representation from department leadership and preceptors, and that there is a mechanism to ensure the oversight needs of individual programs are met.

The RAC is composed of a cross section of clinical, operational, and administrative preceptors.

The program director establishes a process to choose members.

How it will be surveyed

Review of preceptor roster.

Review of RAC roster.

Review of RAC meeting agendas and meeting minutes..

- 4.1.c The RPD may delegate, with oversight, to one or more individuals [(e.g., residency program coordinator(s)] administrative duties/activities for the conduct of the residency program.

Guidance

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

- 4.1.d For residencies conducted by more than one organization (e.g., two organizations in a partnership) or residencies offered by a sponsoring organization (e.g., a college of pharmacy, hospital) in cooperation with one or more practice sites:
 - 4.1.d.(1) A single RPD must be designated in writing by responsible representatives of each participating organization.
 - 4.1.d.(2) The agreement must include definition of:

- 4.1.d.(2)(a) responsibilities of the RPD; and,
- 4.1.d.(2)(b) RPD’s accountability to the organizations and/or practice site(s).

4.2 Residency Program Directors’ Eligibility

RPDs must be licensed pharmacists who:

- have completed an ASHP-accredited PGY1 residency followed by a minimum of three years of pharmacy practice experience; or
- have completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience; or
- without completion of an ASHP-accredited residency, have five or more years of pharmacy practice experience.

Guidance

4.2 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.

4.3 Residency Program Directors’ Qualifications

Guidance

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

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

- 4.3.a leadership within the pharmacy department or within the organization, through a documented record of improvements in and contributions to pharmacy practice;

Guidance

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

- 4.3.b demonstrating ongoing professionalism and contribution to the profession;

Guidance

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).
- moderator or evaluator at regional residency conferences or other professional meeting.
- 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 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

- 4.3.c representing pharmacy on appropriate drug policy and other committees of the pharmacy department or within the organization; and,

Guidance

Examples (demonstrated in the last five years):

- active participation on a multi-disciplinary or pharmacy committee or task force responsible for patient care or practice improvement, etc.
- active participation on the pharmacy and therapeutics committee.
- active participation on a drug policy review committee.
- active participation on an IRB or human subjects committee within the organization.
- 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.

4.4 Residency Program Leadership Responsibilities

RPDs serve as organizationally authorized leaders of residency programs and have responsibility for:

- 4.4.a organization and leadership of a residency advisory committee 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.

- 4.4.b 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 residents progress, 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.

4.4.c implementing use of criteria for appointment and reappointment of preceptors;

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.

4.4.d evaluation, skills assessment, and development of preceptors in the program;

Guidance

RPD evaluates preceptors' competence and uses appropriate methods to evaluate preceptors' skills (e.g., review of residents' evaluations of preceptors, peer review, preceptors' self-assessments, and performance reviews).

How it will be surveyed

Review of processes used for preceptor evaluation, skills assessment, and development.

4.4.e creating and implementing a preceptor development plan for the residency program;

Guidance

Preceptor development plans are documented and include an assessment of needs, a schedule of activities to address identified needs, and a review of effectiveness of development plan. The preceptor development plan could defer to, or be a part of, an organizational plan. Preceptor development plan may be a group plan or individualized plan or a combination of both.

How it will be surveyed

Review of documentation of the program's preceptor development plan addressing new and established preceptors.

Discussion with preceptors and RPD.

4.4.f continuous residency program improvement in conjunction with the residency advisory committee; and,

How it will be surveyed

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

4.4.g working with pharmacy administration.

Guidance

The RPD and pharmacy administration work together to ensure the success of the program.

How it will be surveyed

Discussion with RPD and pharmacy administration.

4.5 Appointment or Selection of Residency Program Preceptors

- 4.5.a Organizations shall allow residency program directors to appoint and develop pharmacy staff to become preceptors for the program.
- 4.5.b RPDs shall develop and apply criteria for preceptors consistent with those required by the Standard.

How it will be surveyed

Review of documentation of criteria for appointment and reappointment.

Discussion with RPD about appointment/reappointment process. (refer to 4.4c)

4.6 Pharmacist Preceptors' Eligibility

Pharmacist preceptors must be licensed pharmacists who:

- have completed an ASHP-accredited PGY1 residency followed by a minimum of one year of pharmacy practice experience; or
- have completed an ASHP-accredited PGY1 residency followed by an ASHP-accredited PGY2 residency and a minimum of six months of pharmacy practice experience; or
- without completion of an ASHP-accredited residency, have three or more years of pharmacy practice experience.

Guidance

4.6 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.

4.7 Preceptors' Responsibilities

Preceptors serve as role models for learning experiences. They must:

- 4.7.a contribute to the success of residents and the program;
- 4.7.b provide learning experiences in accordance with Standard 3;
- 4.7.c participate actively in the residency program's continuous quality improvement processes;
- 4.7.d demonstrate practice expertise, preceptor skills, and strive to continuously improve;
- 4.7.e adhere to residency program and department policies pertaining to residents and services; and,
- 4.7.f 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.

4.8 Preceptors' Qualifications

Preceptors must demonstrate the ability to precept residents' learning experiences as described in sections 4.8.a–f.

Guidance

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

When a list of examples is included in the guidance sections for 4.8.a–f, at least one of the examples is

demonstrated within the last five years unless otherwise noted.

- 4.8.a demonstrating the ability to precept residents' learning experiences by use of clinical teaching roles (i.e., instructing, modeling, coaching, facilitating) at the level required by residents;

How it will be surveyed

Review of residents evaluations of preceptors and their learning experiences.
Discussion with preceptors and residents.

- 4.8.b the ability to assess 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.

- 4.8.c recognition in the area of pharmacy practice for which they serve as preceptors;

Guidance

Preceptors must have one of the following:

Examples:

- BPS certification
- Fellow at a state or national level organization
- Multidisciplinary certification
 - Validated certification that results from an exam and requires reaccreditation on a defined basis by the organization providing certification (i.e., not a one time certificate)
 - Pharmacy related certification recognized by Council on Credentialing in Pharmacy (CCP) 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
- Advanced degree beyond entry level pharmacy degree related to learning experience precepted (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/or peer review

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 will not be impacted by a partial compliance in this area unless greater than 30% of preceptors do not meet one criteria in 4.8c.

4.8.d an established, active practice in the area for which they serve as preceptor;

Guidance

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 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 or pharmacy committee or task force 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.

4.8.e 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 be precepted by a team of preceptors.

How it will be surveyed

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

4.8.f ongoing professionalism, including a personal commitment to advancing the profession.

Guidance:

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)
- 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 ¹
- 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)

¹ 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.

- 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
- teaching of pharmacy students or other health care professionals (e.g., classroom, lab., inservice)

How it will be surveyed

Review of Academic and Professional Record form or PharmAcademic® review

Duration of accreditation will not be impacted by a partial compliance in this area unless greater than 30% of preceptors do not meet one criteria in 4.8c.

4.9 Preceptors-in-Training

4.9.a Pharmacists new to precepting who do not meet the qualifications for residency preceptors in sections 4.6, 4.7, and 4.8 above (also known as preceptors-in-training) must:

- 4.9.a.(1) be assigned an advisor or coach who is a qualified preceptor; and,
- 4.9.a.(2) have a documented preceptor development plan to meet the qualifications for becoming 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.

PGY1 residents may not be preceptors-in-training.

How it will be surveyed

Review of documented plan for preceptor-in-training.

Discussion with preceptors and RPD.

4.10 Non-pharmacist preceptors

When non-pharmacists (e.g., physicians, physician assistants, certified nurse practitioners) are utilized as preceptors:

- 4.10.a the learning experience must be scheduled after the RPD and preceptors agree that residents are ready for independent practice; and,
- 4.10.b a pharmacist preceptor works closely with the non-pharmacist preceptor to select the educational goals and objectives for 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 learning experiences is reflected by a rating of achieved for the residency (ACHR) for the majority of goals and objectives in Competency Area R1.

How it will be surveyed

4.10.a Review of documentation of residents' readiness to work independently.

Standard 5: Requirements of the Sponsoring Organization and Practice Site(s) Conducting the Residency Program

5.1 Residency programs must be conducted only in practice settings that have sought and accepted outside appraisal of facilities and patient care practices. The external appraisal must be conducted by a recognized organization appropriate to the practice setting. Organizations that are not accredited must compare their current performance with national accreditation standards (e.g. NCQA, Medicare Star Rating System).

Guidance

5.1 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., NCQA, URAC]. A college or school of pharmacy that participates in offering a pharmacy residency is accredited by the Accreditation Council for Pharmacy Education (ACPE).

How it will be surveyed

Review of the most recent documentation of recognition. If not accredited, review of organization’s self-assessment against an appropriate set of medication quality measurements (e.g. NCQA, URAC, PQA, Medicare Stars measures, etc)

5.2 Residency programs must be conducted only in those practice settings where staff are committed to seek excellence in patient care as evidenced by substantial compliance with professionally developed and nationally applied practice and operational standards.

Guidance

Reference: *ASHP Best Practices* (available at www.ashp.org) and, when necessary, other pharmacy association guides to professional practice and other relevant standards (e.g., NIOSH, OSHA, 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 Two or more practice sites, or a sponsoring organization working in cooperation with one or more practice sites (e.g., college of pharmacy, health system), may offer a pharmacy residency.

5.3.a Sponsoring organizations must maintain authority and responsibility for the quality of their residency programs.

5.3.b Sponsoring organizations may delegate day-to-day responsibility for the residency program to a practice site; however, the sponsoring organization must ensure that the residency program meets accreditation requirements.

5.3.b.(1) Some method of evaluation must be in place to ensure the purpose of the residency and the terms of the agreement are being met.

5.3.c A mechanism must be documented that designates and empowers an individual to be responsible for directing the residency program and for achieving consensus on the evaluation and ranking of applicants for the residency.

5.3.d Sponsoring organizations and practice sites must have signed agreement(s) that define clearly the responsibilities for all aspects of the residency program.

5.3.e Each of the practice sites that provide residency training must meet the requirements set forth in Standard 5.2 and the pharmacy’s service requirements in Standard 6.

Guidance

Although a residency program may be offered/conducted by more than one organization, there may be only one sponsoring organization designated for a residency program. Sponsorship of a program is determined by the signature of the senior person on the application for accreditation; e.g., if the application is signed by the managed care organization's CEO, the program's sponsor is a the managed care organization, and if it is signed by a Dean, the sponsor is a college of pharmacy.

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

How it will be surveyed

Review of agreements between organizations.

5.4 Multiple-site residency programs must be in compliance with the *ASHP Accreditation Policy for Multiple-Site Residency Programs*⁵.

Standard 6: Pharmacy Practice

6.1 Pharmacy Practice Structure and Management

6.1.a The pharmacy practice environment 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.

How it will be surveyed

Review of:

- survey report of NCQA, URAC or other accrediting body
- pharmacist's state licensure/registration
- discussion with the pharmacist executive and his/her supervisor

6.1.b The pharmacy practice environment has a well-defined organizational structure that supports the safe and effective provision of services, as evidenced by:

6.1.b.(1) mission statement;

How it will be surveyed

Review of the pharmacy mission statement of the sponsoring organization.

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

Guidance:

Written policy and procedures are organized in a manual or electronic format. Policies and procedures are present provision of patient care services, medication errors, adverse drug reactions, and other policies that would be pertinent to the pharmacy practice environment

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

Procedures are in place to ensure all aspects of the medication-use system, including clinical and operational, 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
- procedures and policies for scope of practice
- 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)

Examples include other benchmarking procedures

Discussion about how patient care services are provided proactively.

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 pharmacy
- short- and long-term goals are incorporated into a strategic planning document
- discussion with organization and pharmacy leaders, physicians, nurses and pharmacy staff about the role of pharmacy in strategic planning for the organization and medication use process.

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 NCQA and other accrediting organizations, as applicable

Observation via tour of facilities.

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

Guidance

Examples may include but are not limited to:

- ASHP Best Practices.
- USP Chapter 797/800 requirements (For USP Chapter 800, based on USP implementation schedule).
- [ISMP Targeted Medication Safety Best Practices for Hospitals](#)

Pharmacy leaders meet all applicable practice standards and guidelines, including but not limited to ambulatory care, home care, and long-term care.

How it will be surveyed

Review of compliance with:

- ASHP Best Practices
- USP Chapter 797/800 requirements (For USP Chapter 800, based on USP implementation schedule).
- [ISMP Targeted Medication Safety Best Practices for Hospitals](#) checklist
- policies for oncology pharmacy services and high risk populations

Observation via tour of facilities.

6.2 Pharmacy Resources

The pharmacy practice environment has sufficient resources required to provide services pursuant to the needs of the patient’s served. The pharmacy practice environment:

- 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, e.g. clinical reference information and patient-specific data), computerized systems, patient assessment tools/equipment, and technology necessary to provide the scope of services and promote safe medication use;
- 6.2.e has a system to appropriately document patient care and other services of the practice; and,
- 6.2.f has systems to support the connectivity and interoperability of information systems.

Guidance

6.2.c and 6.2.d are critical factors (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.

6.3 Pharmacy Practice Oversight

- 6.3.a The pharmacy practice must be an integral part of the broader healthcare system in which the residency program is offered, as evidenced by the following:
 - 6.3.a.(1) The healthcare system includes pharmacy in the planning of patient care services and programs related to medication therapy.
 - 6.3.a.(2) The scope of pharmacy services and programs is documented and evidenced in practice and quality measures.

Guidance

Pharmacy is an integral part of the planning and provision of patient care services related to medication therapy.

How it will be surveyed

Review of:
 Minutes of meetings where pharmacy participates in the planning of patient care services
 Pharmacy scope of services document
 Report or dashboard documenting practice (operational) and clinical quality improvement.

- 6.3.b Patient care services and programs are developed and implemented by the practice practice environment based on its mission, and an assessment of pharmacist services and programs needed to provide care to the patients served by the pharmacy practice environment. Patient care services and programs are delivered utilizing three delivery models:
 - 6.3.b.(1) individual patient care in which the pharmacist communicates recommendation to patients and their health care providers;
 - 6.3.b.(2) care provided to targeted groups of patient in which the pharmacist designs, conducts, monitors and evaluates the outcomes of organized and structured programs; and
 - 6.3.b.(3) population care management in which the pharmacist develops and implements medication-use policy.

Guidance:

How it will be surveyed

Review of the mission statement and pharmacy services assessment document
Review of completeness of patient care services and programs delivery models descriptions
Review of the clinical outcomes of these delivery models.

6.3.c. The pharmacy practice environment staff must provide leadership and participate with other health professionals in the following systems to ensure safe and effective patient care outcomes and to continuously improve the medication-use systems used in the pharmacy practice environment (as applicable to the pharmacy practice environment):

- 6.3.c.(1) A system to support and actively participate in decision-making concerning the pharmacy and therapeutics function, including the preparation and presentation of drug-therapy monographs.
- 6.3.c.(2) A system to review medication-use evaluations and to implement new policies or procedures to improve the safe and effective use of medications.
- 6.3.c.(3) A system to review reported adverse drug events and to implement new policies and procedures to improve medication safety.
- 6.3.c.(4) A system to evaluate routinely the quality of pharmacy services and programs provided.

Guidance:

6.3.c(1)-(4) are critical factors (see Glossary for definition of “critical factor”).

The pharmacy director will be able to describe the structure and charge of the organizational committees which oversee the drug formulary, medication use evaluations, adverse drug event report assessments and quality of pharmacy services routine assessments.

How it will be surveyed

Review of agenda and minutes of committees which oversee these activities

6.4 Pharmacists’ Roles/Responsibilities

The following patient care services and activities are provided by pharmacists in collaboration with other healthcare professionals to optimize medication therapy for patients:

- 6.4.a Membership on interprofessional teams in healthcare areas.
- 6.4.b Development of medication use guidelines to promote safe and effective therapy.
- 6.4.c Prospective participation in the development of clinical plans for populations and individual patients.
- 6.4.d Identification and resolution of medication-related problems.
- 6.4.e Mechanisms for review of the appropriateness and safety of medications.
- 6.4.f Design and implementation of medication-therapy monitoring.
- 6.4.g A system of training and peer-review to ensure the quality of pharmacists’ action in providing services and programs.
- 6.4.h Track and document patient care recommendations.
- 6.4.i Written and oral consultations regarding medication therapy management.
- 6.4.j Disease and/or drug therapy management programs consistent with laws, regulations, and practice environment policy.
- 6.4.k Disease prevention and wellness promotion programs.
- 6.4.l A system to ensure and support transitions and continuity-of-care activities with other healthcare professionals.
- 6.4.m Developing and maintaining a formulary.
- 6.4.n Educating healthcare providers on timely medication-related matters and medication policies.

- 6.4.o Developing and providing educational information about medications, medication therapy, and other medication-related matters for patients.
- 6.4.p Providing leadership to and participating in the development or modification of policies and programs related to clinical quality of: (1) medications; (2) medication-use evaluation; (3) adverse drug event prevention, monitoring, and reporting; (4) medication adherence; and (5) appropriate methods to assess ongoing compliance with such policies and programs.

Guidance

6.4.a-f, 6.4h, and 6.4j are critical factors (see Glossary for definition of “critical factor”).

How it will be surveyed

Review of services provided.

6.5 Continuous Quality Improvement

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

Guidance

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

This includes routine quality improvement for clinical and operational services.

How it will be surveyed

Discussion with appropriate practice site staff.

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

Guidance

6.5.a(1) is a critical factor (see Glossary for definition of “critical factor”).

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, , disease management services, utilization management programs, medication safety initiatives, care transitions, and other patient care services provided in the practice).

Documentation of pharmacist-provided patient care outcomes over time demonstrating improvement of specific quality indicators (e.g., HbA1C, Lipid levels, BP)

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 The pharmacy practice environment personnel must 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 The pharmacy practice environment’s assessment and improvement process must include assessing and developing skills of the pharmacy practice environment’s staff.

How it will be surveyed

Review of documentation of improvement initiatives for pharmacy staff skill improvement and resulting changes implemented, where 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) Managed Care Pharmacy Residency Programs* for a complete list.

Approved by the ASHP Board of Directors September 23, 2016. Approved by the Academy of Managed Care Pharmacy Board of Directors October 3, 2016. For existing programs this revision of the accreditation standard will take effect July 1, 2017. The effective date for implementation of this standard is commencing with the entering resident class for 2017.

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