ASHP ACCREDITATION STANDARD

FOR POSTGRADUATE PHARMACY RESIDENCY PROGRAMS

Introduction

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

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

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

Application of The Standard

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

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

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

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

Overview of The Standard

Standard 1: Recruitment and Selection of Residents

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

Standard 2: Program Requirements and Policies

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

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

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

Standard 4: Requirements of the Residency Program Director and Preceptors

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

Standard 5: Pharmacy Services

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

Glossary of Terms and Acronyms can be found at the end of the document.

Standard 1: Recruitment and Selection of Residents

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

    1.1.a   Description of methods for recruitment consistent with sponsoring institution's mission and strategic aims. Programs must engage in mission-driven, ongoing, systematic efforts to recruit and retain individuals of diverse backgrounds.

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

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

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

    1.1.e   Description of Phase II Match procedures.

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

Guidance
- 1.1:
  - Recruitment, evaluation and ranking procedure appears in the residency manual or other readily available residency or pharmacy department documents, but does not need to be shared with applicants.
  - Programs ensure the documented procedure aims to reduce implicit bias throughout the continuum of the recruitment, selection, and ranking process.
  - Applicant selection process should include the residency program director and others involved in the conduct of the residency program.
- 1.1.a: Programs implement innovative strategies that promote recruiting and retention of a diverse workforce consistent with applicable laws and organizational mission that meets the needs of all patients and is reflective of the service demographic. Evaluation of workforce diversity should include an assessment of the demographic population in the area served by the program and the program's efforts to recruit and retain a diverse workforce including individuals underrepresented in pharmacy. It is important to note that these standards do not require race-based affirmative action in promoting or achieving diversity.
  - International programs are exempt from meeting this standard item. During surveys, 'N/A' should be indicated on the pre-survey questionnaire for international programs.
- 1.1.b:
  - Procedures include information on how the academic performance of applicants from pass/fail institutions are evaluated, if GPA is part of the applicant selection criteria.
  - A documented applicant screening rubric.
- 1.1.c: Pre-determined interview questions and defined criteria for rating applicant's interview performance.
- 1.1.d, 1.1.e, 1.1.f: International programs exempted by ASHP from the Match must have documentation of the country's official application and selection process. "N/A" should be indicated on the pre-survey questionnaire; however, documentation shall be provided in survey materials as requested.

How it will be surveyed
Review of:

- Documented procedure for recruitment, evaluation and ranking of applicants.
- Tools and rubrics used.
- Recruitment materials.
- Predetermined criteria used to select applicants to interview and rank.
- Discussion with RPD and others involved in the applicant selection process.

1.2   Programs' applicant selection process ensures the following:

    1.2.a   Applicants are licensed or will be eligible for pharmacist licensure in the state(s) or jurisdiction(s) as required by the program (or equivalent registration in the country if outside of the US) by the start of the residency program.

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

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

Guidance
- 1.2: Process appears in the residency manual or other readily available residency or pharmacy department documents.
- 1.2.a:
  o For programs in the US or US territories: To be eligible for pharmacist licensure, candidates must be graduates or candidates for graduation from an ACPE accredited degree program (or one in the process of pursuing accreditation) or have a Foreign Pharmacy Graduate Examination Committee (FPGEC) certificate from the NABP.
  o Applicants to non-traditional programs have graduated from an ACPE-accredited program or one in the process of pursuing accreditation and are licensed at the time of application.
  o An FPGEC certificate indicates that the candidate graduated from a pharmacy school outside of the US and is eligible for pharmacist licensure. FPGEC status is not related to citizenship or VISA sponsorship.
  o Jurisdiction pertains to federal programs (e.g., Veterans Administration, DOD, USPHS, and IHS) in which pharmacists may practice as long as they maintain pharmacist licensure in any state or U.S. territory.
- 1.2.b: To be eligible for a PGY2 residency, candidates have completed or be in the process of completing an ASHP-accredited or candidate-status PGY1 residency. See Standard 2.7 for the process to verify actual completion once the resident starts the PGY2 program.

How it will be surveyed:
Review of:
- Applicant selection procedure.
- Predetermined criteria used to select applicants to interview and rank.

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

Guidance
- 1.3 is a Critical Factor (see Glossary for definition of "Critical Factor").
- PGY1/2 Combined Residency Programs recruit residents for both the PGY1 and PGY2 year for the residency programs specified in the program's residency application.
  o The program is allowed to recruit a resident only for the PGY2 residency year if the current PGY1/PGY2 resident withdraws or is dismissed from the residency during their PGY1 year.

- o Programs must contact the Accreditation Services Office to recruit a resident only for the PGY2 residency year.
- The following residency programs are not required to offer positions through the Resident Matching Program per the *Rules for the ASHP Pharmacy Resident Matching Program*:
  - o IHS residency positions.
  - o USPHS and DOD residency positions offered exclusively to commissioned pharmacy officers.
- Residency programs not required to offer positions through the ASHP Resident Match Program, as listed above, are required to report the number positions filled annually to the ASHP Accreditation Services Office by April 1st. This may be done by each individual program or collectively for programs utilizing the same process for hiring exempt residency positions (i.e., IHS). The date by which applicants accept or decline residency positions offered through the IHS match process occurs prior to the initial date applicants may submit Rank Order Lists for Phase I of the Match.
- Residency programs conducted outside of the US and US territories are exempt from the Match but can choose to participate, if desired. These programs may participate in a matching program offered by or required by governmental agencies or accrediting bodies in their country.

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

Standard 2: Program Requirements and Policies

2.1   The minimum term of resident appointment is 52 weeks.

   2.1.a   For international PGY1 residency programs, the minimum term of residency appointment is extended to meet the requirements of The Standard.

Guidance
- 2.1:
  - o Applies to PGY1 residency programs whose applicants graduate from ACPE accredited pharmacy degree programs and to all PGY2 programs.
  - o PGY1 residents in 24 month combined PGY1/PGY2 residency programs complete a minimum of 52 weeks of training prior to starting the PGY2 residency program.
- 2.1.a:
  - o Is not applicable for international PGY1 programs whose applicants graduate from ACPE-accredited pharmacy degree programs.
  - o International programs seeking accreditation must contact the Accreditation Services Office at ASHP to establish a required program duration.
  - o The usual duration of international PGY1 residency programs is 24 months to ensure residents achieve the required competency areas, goals, and objectives.

How it will be surveyed
- 2.1:   Review of program structure, learning experience descriptions, and residents' schedules in PharmAcademic™.
- 2.1.a: Review of deliverables completed by residents.
- 2.1.a: Discussion with RPD.

2.2   Policies define the amount of time residents are allowed to be away from the program.

   2.2.a   Time away from the residency program does not exceed a combined total of the greater of (a) 37 days per 52-week training period, or (b) the minimum number of days allowed by applicable federal and/or state laws (allotted time), without requiring extension of the program.

        2.2.a.1   Training is extended to make up any absences that exceed the allotted time and extension beyond the allotted time is equivalent in competencies and time missed.

   2.2.b   Policies define whether extension of the program is permitted (subject to the requirements of any applicable federal and/or state laws).

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

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

Guidance
- 2.2.a:
  - For the purposes of the Standard, time away from the program is defined as the total number of days taken for vacation, sick, interview, and personal days; holidays; religious time; jury duty; bereavement leave; military leave; parental leave; leaves of absence; and, extended leave.
    - The calculation of time away DOES NOT include service commitment/staffing days nor are compensatory days for staffing shifts counted in the calculation.
  - The Standard DOES NOT define the amount of paid leave that must be offered to residents; organizations should follow their routine paid time off policies and procedures.
  - The Standard DOES NOT require programs to offer residents 37 days of paid time away from the program.
  - The Standard DOES define the maximum number of days a resident may be away from the program before an extension is required (37 days) to fulfull the 52-week commitment.
  - If a resident exceeds 37 days away from the program, in order to fullfil the requirements of the Standard, the program must be extended by the number of days the resident is away from the program in excess of 37. If the organization is not able to extend the residency program, the resident will not be eligible to receive a residency completion certificate.

How it will be surveyed
- Review of program's leave policies.
- Discussion with RPD.

2.3   Programs ensure compliance with the *ASHP Duty Hour Requirements for Pharmacy Residencies* through the development of program policies, processes, or program documents as it applies to the following:

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

   2.3.b   A process for monitoring compliance on a monthly basis includes:

> 2.3.b.1   Documenting compliance with all duty hour requirements including hours worked, hours free of work, moonlighting, and frequency of all on-call programs.
>
> 2.3.b.2   Process for assessing instances of non-compliance and actions to be taken to prevent exceeding duty hours.

2.3.c   Documentation of moonlighting policy.

2.3.d   Documentation of the type of and requirements of on-call programs, if applicable.

Guidance
- 2.3:
  - Residency program directors and preceptors have the professional responsibility to provide residents with a sound training program that must be planned, scheduled, and balanced with concerns for patients' safety and residents' well-being and resilience.
  - Program policies appear in the residency manual (written or electronic) or other readily available pharmacy department documents.
- 2.3.a: The web link is included to assure that programs and residents have access to review the most up to date requirements. An alternative is to include the entire current *ASHP Duty Hour Requirements for Pharmacy Residencies* in your program's duty hour policy.
- 2.3.b.1: Tracking of residents' hours to ensure they have not exceeded duty hour limits may be accomplished by attestations of compliance by the resident (written or generated from PharmAcademic™), work hours/resident schedules, or timesheets.
- 2.3.c: Moonlighting policy, which can be included in the program's duty hour policy, should state whether moonlighting is allowed and if yes, what type (e.g., internal, external) and maximum hours allowed. The policy should include a structure for approval and actions that will be taken if moonlighting affects the resident's performance.

How it will be surveyed
Review of:
- Documentation of duty hours and moonlighting policies, processes, or program materials.
- Documentation of monthly attestations, work hours/schedules or timesheets.
- Discussions related to duty hour practices and procedures.

2.4   Requirements for Licensure

2.4.a   Residents are licensed pharmacists in the state(s) or jurisdiction(s) as required by the program (or equivalent registration in the country if outside of the US) prior to or within 120 days after the program start date.

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

Guidance
- 2.4.a and 2.4.b are Critical Factors (see Glossary for definition of "Critical Factor").
- Program policies appear in the residency manual (written or electronic) or other readily available pharmacy department documents.
- 2.4b:
  - Programs may choose a required licensure date that is sooner than 120 days as long as all policies and requirements are clear.

- - Residents not licensed within 120 days after the program's start date must either be dismissed from the program or the resident's term of appointment extended by the number of days the resident is without licensure past the 120-day deadline.
  - For PGY1/PGY2 combined programs, residents not licensed within 120 days after the start of the program must either be dismissed from the program or the resident's term of appointment for their PGY1 year extended by the number of days the resident is without licensure past the 120-day deadline. Further, the resident's PGY2 year start date must be delayed until after the resident has completed the PGY1 year, and the resident's PGY2 end date must be adjusted to ensure the PGY2 program is 52 weeks in duration.
  - In a 52-week residency program, 120 days (17 weeks) is one-third of the program, therefore residents must complete at least 35 weeks of their residency as a licensed pharmacist to meet the two-thirds requirement.
  - A program that has a term of appointment greater than 52 weeks may allow a licensure requirement greater than 120 days as long as the resident completes at least two-thirds of their residency as a licensed pharmacist.
  - Programs that offer extensions or suspensions specify the status of salary and benefits during that period. If the program is extended, policies must describe the maximum extension allowed and whether the resident will be paid during the extension.
  - If the program chooses to suspend the resident until they are licensed and re-start the program, the maximum duration of suspension is defined and along with the status of salary and benefits.
  - Program policies for extensions, suspensions, and extenuating circumstances ensure that the resident is licensed for two-thirds of the program.

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

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

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

2.5.a.1   The minimum threshold related to educational objectives that would allow awarding a certificate of completion.

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

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

2.5.d   Other requirements as defined by the program.

Guidance
- 2.5: PGY1 residents in 24 month combined PGY1/PGY2 residency programs have the same requirements for completion of their PGY1 residency as other PGY1 residents in the residency program.
- 2.5.a:
  - As specified in 3.1.b.1, the program's structure is designed to facilitate achievement of all required objectives, however individual residents are not required by The Standard to achieve all objectives unless required by the program.
  - In PharmAcademic™, achievement of objectives for the residency is designated as "ACHR". Examples of ACHR requirements include but are not limited to: Program designates percent

or number of objectives that must be achieved for residency (ACHR), identifies specific objectives that must be achieved for residency (ACHR), or a uses a combination of the two methods.

- 2.5.b:
  - o Required deliverables differ based on program type. See glossary for definition of "deliverable".
  - o 24 month combined PGY1/PGY2 programs may allow residents to complete their project over two years. If the PGY1 project continues into the PGY2 year, the PGY1 deliverable includes an interim report that is presented both verbally and in a written format.
- 2.5.c: CAGOs for certain program types include a required appendix. Programs of these types must include the appendix requirements in their program's completion requirements.
- 2.5.d: Possible examples of other requirements defined by programs include minimum staffing requirements, and completion of a teaching certificate.

How it will be surveyed

Review of:

- List of successful completion requirements in program's documents.
- Review of deliverables from residents who successfully completed the residency program.

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

Guidance

- Program policies appear in the residency manual (written or electronic) or other readily available pharmacy department documents.
- The residency-specific remediation/disciplinary policy is intended to address issues that are not specifically covered by the organization's disciplinary policy (e.g., plagiarism, unprofessional behavior).
- The policy defines and addresses the procedure followed for resident(s) failing to progress as expected during the residency, including when failure to progress would result in withholding the certificate of completion, extension of the program, or dismissal from the residency program.
- Programs that offer extensions specify the status of salary and benefits during that period. If the program is extended, policies must describe the maximum extension allowed and whether the resident will be paid during the extension.
- Programs can link residency-specific policy to the organization's disciplinary policy. Residency-specific policies should be reviewed by the Human Resources department to ensure consistency with organization's policies. For international programs, such policies are also consistent with policies of accrediting bodies.

How it will be surveyed

Review of:

- Residency-specific remediation/disciplinary policy.
- Discussion with RPD.

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

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

Guidance

- 2.7 is a Critical Factor (see Glossary for definition of "Critical Factor").
- 2.7: Options for verification include, but are not limited to, direct communication with PGY1 RPD, graduate tracking in PharmAcademic™, or PGY1 certificate of completion. If a method to other than graduate tracking in PharmAcademic™ is used to complete the verification, documentation of verification must be retrievable.
- 2.7.a: Procedure includes either the number of days prior to or after the PGY2 start date or the actual date by which the verification needs to be completed, provided the duration of time is less than 30 calendar days after the start of the PGY2 program or less than 90 calendar days after the start of the PGY2 year in PGY1/2 combined program.

How it will be surveyed
- Review of procedure and verification documentation.

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

   2.8.a   Leave policies.

   2.8.b   Duty-hour policies.

   2.8.c   Licensure policy.

   2.8.d   Requirements for successful completion of the program.

   2.8.e   Residency-specific remediation/disciplinary policy.

   2.8.f   Program start date and term of appointment.

   2.8.g   Stipend and benefit information.

   2.8.h   Financial support for required professional meeting attendance.

Guidance
- 2.8:
  - In lieu of emailing policies, programs can provide applicants a link to their policies. An alternative is to provide the applicant the residency manual or appropriate excerpts from the residency manual if the policies are contained in the manual.
  - As part of the interview process, candidates have the opportunity to ask questions about residency policies that were provided with the interview invitation.
  - Organizations with multiple residency programs develop a single source of residency policies to be used by all programs.
  - In accordance with the *ASHP Regulations on Accreditation of Pharmacy Residencies*, programs disclose, at the time the interview invitation is extended, if their structure includes required travel to experiences that are not conducted at the Primary Practice Site(s). The following information is also provided:
    - The number of required learning experiences that are not conducted at the Primary Practice Site.
    - Financial support (e.g., mileage reimbursement, parking fees, tolls), if provided per the organization's travel policy.
- 2.8.a: Leave policies include policies specified in Standard 2.2.a.
- 2.8.f:
  - Term of appointment is defined and consistent with Standard 2.1.

o Acceptable to provide approximate start date if exact date is not finalized before the time the applicant is invited to interview.
• 2.8.g: Residency programs are required to provide a stipend and benefits. Benefit information includes vacation, holiday, professional, and sick leave allotment and whether health insurance is available.
• 2.8.h: Examples of required meetings include pharmacy association meetings and regional residency conferences. If exact amount of financial support is not known at the time the applicant is invited to interview, or if no financial support is provided, that information is communicated to the applicant.
How it will be surveyed
• Review of program policies and information provided to candidates invited to interview.

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

    2.9.a The program also provides general information about the hiring process, including pre-employment requirements and confirmation of program start date and term of appointment.

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

Guidance
• 2.9: Documented communication in writing may be in the form of an email.
• 2.9.a:
o Pre-employment requirements may include human resources requirements such as application for employment, drug testing, criminal record check, health screenings, and immunizations.
o Term of appointment is defined and consistent with Standard 2.1.
o If a program requires their matched candidates to accept residency policies with the Match acceptance acknowledgement; the policies must still be reviewed with residents within 14 days of the start of the program, and the review is documented (e.g., included as part of an orientation checklist).
How it will be surveyed
• Review of an example of the communication from the program to each matched candidate.
• Review of information provided to matched candidates (e.g., pre-employment information).

2.10 The RPD or designee reviews program policies with matched candidates and acceptance is documented within 14 days from the start of the residency.

Guidance
Program policies include those listed in 2.8.
How it will be surveyed
• Review of program policies provided to matched candidates.
• Review of documented acceptance of program policies by matched candidates.
• Discussion with residents.

2.11 The program has developed a residency manual.

Guidance

The residency manual (written or electronic) includes information on the practice site, program structure, program participants and roles, completion requirements, residency policies (or information on where located), program's overall evaluation strategy including evaluations required and the defined rating scale for summative evaluations (see Standard 3), and other information pertinent to residents (e.g., residency project guidelines).

How it will be surveyed
- Review of program's residency manual content.

2.12   The residency program provides adequate resources to residents including:

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

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

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

Guidance
- 2.12.b: Examples of technology include a laptop or work station, access to clinical information systems, databases, and references.
- 2.12.b.1: Technology and equipment provided is comparable to that provided to the organization's other remote workers.

How it will be surveyed
Review of:
- Program's manual.
- Residents' work space.
- Resident interview.

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

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

    2.13.b   The requirements for awarding a certificate of completion match the program's documented completion requirements.

Guidance
- 2.13 is a Critical Factor (see Glossary for definition of "Critical Factor").
- See Standard 2.5 for guidance on "requirements for successful completion".
- 2.13.a: Final documentation of residents' completion of the program's requirements can be documented in the same document used for quarterly tracking of progress towards completion requirements as described in Standard 3.3.e.
- First year residents in a combined program with a Master's degree will have fifteen (15) months to successfully meet all project related requirements for completion of their PGY1 residency program in accommodation for completion of required didactic courses.

2.14 The certificate of completion provided to residents who complete the program's requirements is issued in accordance with the provisions of the *ASHP Regulations on Accreditation of Pharmacy Residencies.*

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

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

2.14.b.1 Organization name.

2.14.b.2 Residency program type.

2.14.b.3 City and state where located.

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

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

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

Guidance
- 2.14:
  - 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 is encouraged and, if used, follows all applicable rules and the ASHP Style Guide as published by ASHP on the accreditation website (see Residency Accreditation Tools: Program Logo). PGY1 programs follow *ASHP Regulations on Accreditation of Pharmacy Residencies* regarding naming of their program (see additional guidance under Standard 2.15.a).
  - Residents in 24 month PGY1/PGY2 combined programs are awarded a PGY1 certificate upon completion of the PGY1 program requirements and a PGY2 certificate upon completion of the PGY2 program requirements.
  - The certificate includes the end date of the residency.
- 2.14.a: Additional signators may be included on the certificate.
- 2.14.b.1: Organization name matches the name of the organization (or organizations) as listed in the ASHP Residency Directory.
- 2.14.b.2: Following are the approved names for program type:
  - PGY1 Pharmacy Residency

- o   PGY1 Community-Based Pharmacy Residency
- o   PGY1 Managed Care Pharmacy Residency
- o   PGY2 (*insert type as listed in title of Competency Areas, Goals, and Objectives document*)
     Residency
- 2.14.b.2: Modifiers to the type of program (e.g., PGY1 Pharmacy Residency *in Ambulatory Care*)
  are <u>not</u> allowed.
- 2.14.b.3: For international programs, the certificate includes city and country where located.

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

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

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

2.15.b   Program uses PharmAcademic™ for residency program management and
maintenance, including:

2.15.b.1   Program's objective assignment grid.

2.15.b.2   Learning experience descriptions.

2.15.b.3   Residents' schedules.

2.15.b.4   Evaluations listed in Standards 3.4 and 3.5.

2.15.b.5   Residents' development plans.

2.15.b.6   Resident close-out documentation.

2.15.c   A record of each residents' program application, acceptance letter, documented
acceptance of program policies; copy of each resident's licensure, deliverables,
documentation of completion requirements; and each resident's signed residency
certificate of completion is kept since last accreditation site survey.

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

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

- 2.15.b: Program's objective assignment grid has also been referred to by names such as the "taught and evaluated grid", "TE grid", or "TE assignment report".
- 2.15.c:
  - Residents' program applications submitted electronically must be downloaded and retrievable.
  - Regulation (VII.B.): *"Records (to include, residents' applications, residents' acceptance letters, residents' plans, all evaluations, residents' projects, and copies of certificates) for residents trained by an ASHP-accredited program since the last site survey (i.e., up to eight years) must be maintained and available to the survey team for review. These records may be maintained electronically, as long as they can be easily accessed, if requested by the survey team."*

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

2.16   When more than one organization (e.g., college of pharmacy, health system) shares responsibility for the financial and/or management aspects of the residency, the Program Operator maintains authority for the residency program and responsibility for meeting The Standard.

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

2.16.a.1   Designation of a single Residency Program Director (RPD).

2.16.a.2   RPD responsibilities.

2.16.a.3   RPD's accountability to the Program Operator.

2.16.a.4   A documented mechanism that designates and empowers the RPD to achieve consensus on the evaluation and ranking of applicants to the residency program.

2.16.a.5   A mechanism for designating practice site coordinators for organizations where the RPD does not maintain an active practice.

2.16.a.6   A method for coordinating the conduct of the residency program within all organizations.

2.16.a.7   A method of evaluation to ensure terms of agreement are met.

Guidance
- 2.16: The Program Operator is the organization (e.g., hospital, college of pharmacy, corporation, federally qualified healthcare center (FQHC), outpatient clinic, or other business entity) that applies for accreditation, and is administratively responsible for compliance with The Standard.

- 2.16.a: This relationship must be agreed to in writing and signed by all parties (i.e., memorandum of understanding (MOU) and complies with Standard 2.16.a.1-7.
- 2.16.a.5: Refer to the *ASHP Regulations on Accreditation of Pharmacy Residencies*.

How it will be surveyed
- Review of signed and dated current agreement.
- Discussion with RPD.

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

Guidance
Refer to the *ASHP Regulations on Accreditation of Pharmacy Residencies*.

How it will be surveyed
- Review of residency agreements, as applicable.
- Discussion with RPD.

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

3.1   Program Structure and Design

3.1.a   The program structure is documented and includes:

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

3.1.a.2   Duration of each learning experience.

3.1.a.3   For learning experiences that are twelve or more weeks in duration, if specific time is scheduled on a recurring basis, the schedule is clearly documented.

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

Guidance
- 3.1.a.1 is a Critical Factor (see Glossary for definition of "Critical Factor").
- 3.1.a.1:
  o The design of the program ensures that at least half of the residency year is scheduled in required learning experiences inclusive of longitudinal experiences.
  o Required experiences also include those designated as "selective required" experiences that are used in some program design structures. For example, in some program structures, residents may select one of multiple learning experience options in critical care, internal medicine, ambulatory care, etc. Program structures which incorporate "selective required" options must ensure that the options within each "selective" category provide similar opportunities for skill development (e.g., assigned objectives); exposure to similar patient populations/levels of acuity; consistent levels of preceptor engagement with the healthcare team, and similar scope of preceptor resposiblities in the practice area.
  o Residency program structures that include different tracks can differentiate each track only through elective learning experiences. The required learning experiences must be the same

for all residents. For example, a PGY1 residency with tracks for pediatric, adult, and mental health focus can limit residents choosing each track to specific elective learning experience choices but differentiation in required learning experiences is not allowed.

- o For residency programs that offer a traditional and a non-traditional track, required learning experiences are the same for both tracks.
- o Residents in 24 month combined PGY1/PGY2 residency programs have the same required learning experiences as the other PGY1 residents. Only elective learning experiences can be different in the PGY1 year for residents in combined PGY1/PGY2 programs.
- o Naming of learning experiences is consistent among manual, promotional materials and PharmAcademic™.
- o List of required and elective learning experiences are consistent among program documents.
- o All listed learning experiences have a fully developed learning experience description documented in PharmAcademic™.
- o Promotional and program materials list only elective learning experiences that have been fully developed. However, promotional materials may include a statement that "other elective learning experiences may be developed based on resident interest and preceptor availability".
- o Programs are not required to offer elective learning experiences.
- 3.1.a.2:
  - o The structure includes the duration (e.g., 6 weeks, 3 months, 52 weeks) of each learning experience. Ranges in duration for learning experiences should be limited to no more than 2 weeks variation (e.g., 4-6 weeks). The use of ranges for multiple learning experiences should not impact the overall basic structure of the program or impact the number of elective learning experiences available for each resident.
  - o Programs can extend a learning experience due to conferences, vacations, interviews, or other time away from the learning experience.
  - o Non-traditional program structures ensure that learning experiences are scheduled such that residents complete non-longitidinal learning experiences without interruption (e.g., a four-week learning experience cannot be split into four, one-week experiences with staffing responsibilities every other week).
- 3.1.a.3: The following are examples of learning experiences with residents' time scheduled on a recurring basis:
  - o *Hepatitis clinic: 12 weeks, a half-day every Tuesday.*
  - o *Staffing: 40 weeks, 10-hour shifts every other weekend.*
  - o *Project: 48 weeks, 1 day per month is a dedicated project day.*
- See ASHP website for examples of program structure documentation.
- 3.1.a.4: The initial learning experience scheduled for residents includes orientation to the residency program and practice environment. Orientation to the residency program includes, at minimum, orienting residents to the:
  - o Residency manual (see Standard 2.11 guidance for required contents of residency manual).
  - o Residency's purpose, as documented in the introduction to The Standard.
  - o The Standard.
  - o Competency areas, goals, and objectives applicable to the residency program.
  - o Description of required and, if applicable, elective learning experiences.
  - o Organization's process for reporting issues around harassment and inappropriate behavior, if not covered by the organization's orientation for new employees.
  - o Strategies for maintaining well-being and resilience and providing available resources.
- NOTE: For PGY2 residents who completed their PGY1 year at the same practice site, only orientation to the residency program is required.

How it will be surveyed
- Review of documented structure in program and promotional materials.

- Review of residents' schedules in PharmAcademic™.
- Review of program's taught and evaluated (TE) grid in PharmAcademic™.
- Review of orientation learning experience description.
- Discussion of orientation with the RPD and residents.

3.1.b Competency Areas, Goals, and Objectives (CAGOs)

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

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

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

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

Guidance
- 3.1.b.1, 3.1.b.1.a, 3.1.b.1.b, and 3.1.b.1.c are Critical Factors (see Glossary for definition of "Critical Factor").
- 3.1.b.1.a:
  o The number of times each required objective needs to be assigned to required learning experiences depends on the type and complexity of the objective and each program's design and structure. For example, patient care objectives are typically assigned to more than one required learning experience. However, major project objectives may be assigned only once to a required learning experience. For programs with a longitudinal structure, assigning patient care objectives to one required longitudinal learning experience may be sufficient as the objectives are evaluated more than once.
  o Elective objectives are objectives that are not required by the Competency Areas, Goals, and Objectives. Programs may select elective objectives for the program, a specific learning experience, or a specific resident.
- 3.1.b.1.b: The program reviews the Appendix requirements and considers how they are best addressed in the program structure. The program develops a documented method for tracking Appendix requirements.

How it will be surveyed
- Review of documented structure in program and promotional materials.
- Review of program's taught and evaluated (TE) grid in PharmAcademic™.
- 3.1.b.1.b: Review of Appendix tracking tool.

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

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

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

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

Guidance

• 3.1.c.1 is a Critical Factor (see Glossary for definition of "Critical Factor").
• 3.1.c.1-3.1.c.3:
   o PGY1 includes PGY1 Managed Care Pharmacy, PGY1 Community-Based Pharmacy, and PGY1 Pharmacy residencies.
   o PGY2 Direct Patient Care Residencies encompass all PGY2 residencies that include "Competency Area R1: Patient Care", as part of the required competency areas, goals, and objectives for the residency program.
• 3.1.c.2:
   o For ambulatory, managed care, and community-based pharmacy settings, residents gain practice and experience in patient care delivery that involves continuity of care and the development of extended patient relationships (i.e., care includes the initial patient encounter and at least one follow-up encounter).
   o For acute care settings, residents gain experience in taking care of patients during their stay relative, to the specific learning experience. For example, for residents on a critical care learning experience, care includes routine follow-up throughout the patient's stay in the ICU. It is not required for acute care settings to include an ambulatory care learning experience for residents to gain experience in recurring patient follow-up.
• 3.1.c.3: Patient Care Activities are activities performed by pharmacists with the intent of contributing to positive pharmacotherapeutic and health outcomes of individual patients. Care is in collaboration and communication with other members of the health care team with responsibilities for the individual patient. Communication may be face-to-face, telephonically, virtually, or in writing.

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

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

Guidance
• Examples of patient disease states include but are not limited to hypertension, diabetes, hepatitis C, and hyperlipidemia. • Examples of populations include but are not limited to oncology, critical care, cardiology, infectious diseases, and patients with inflammatory diseases. Populations also include specific patient care services (e.g., anticoagulation clinic patients, transitions of care). • This does not apply to age-specific populations (e.g., geriatrics, pediatrics, adult).
How it will be surveyed
• Review of the program's structure, residents' schedules, and learning experience descriptions. • Discussion with preceptors, residents, and other health care providers.

3.1.c.5   Residents are provided sufficient opportunities to provide direct patient care to patients with the required disease states and conditions as defined in the advanced practice area Appendix.

Guidance
• 3.1.c.5 is a Critical Factor (see Glossary for definition of "Critical Factor").

- Only applies to programs with accompanying Appendices to their Competency Areas, Goals, and Objectives.
- Programs may partner with other organizations to develop learning experiences that will address gaps in patient populations where direct patient care experience is required by the Appendix.

How it will be surveyed
- Review of the program's structure and learning experience descriptions.
- Review of Appendix tracking documentation.
- Discussion with RPD, preceptors, and residents.

3.2   Learning Experiences

    3.2.a   Learning experience descriptions are documented and include:

        3.2.a.1   A general description, including the practice area.

        3.2.a.2   The role of pharmacists in the practice area.

        3.2.a.3   Expectations of residents.

        3.2.a.4   Resident progression.

        3.2.a.5   Objectives assigned to the learning experience.

        3.2.a.6   For each Objective, a list of learning activities that facilitate its achievement.

Guidance
- 3.2.a.6 is a Critical Factor (see Glossary for definition of "Critical Factor").
- 3.2.a:
  - Preceptors are involved in the development of learning experience descriptions.
  - Learning experience descriptions are documented in PharmAcademic™.
- 3.2.a.1: The description of the practice area may include types of patients, members of the healthcare team, patient care focus, and typical patient load.
- 3.2.a.2: The role of the pharmacist describes the pharmacist's (not the residents) daily responsibilities in the practice area, for both direct patient and non-direct patient care learning experiences.
- 3.2.a.3: In addition to daily or weekly responsibilities, expectations of residents may include required presentations, topic discussions, projects, assignments, and meeting attendance.
- 3.2.a.4:
  - Resident progression describes the expectation for resident skill development over the duration of the learning experience. Progression timelines are documented in each learning experience. If more than one learning experience in the same practice area is offered (e.g., Patient Care 1 and Patient Care 2), the expected progression reflects advanced expectations.
  - For longitudinal learning experiences that include dedicated, concentrated time for specific activities (e.g, longitudinal research experience includes December as a project month); the progression section of the description includes timeframes and specific resident expectations for the concentrated portion (e.g., Dec. 10-31: Resident will begin to collect and analyze data).
- 3.2.a.5: At least one objective is assigned to each learning experience.

- 3.2.a.6: Learning activities are specific to the practice area, unique to the objective, and developed at the cognitive learning level (Bloom's Taxonomy) associated with the objective. Note: Criteria associated with each objective are meant to guide the preceptor on assessing the resident and not to be used as learning activities.
- See learning experience description example and example activities on ASHP website.

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

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

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

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

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

Guidance
- The preceptor role may vary based on residents' progression.
    - Direct instruction at level appropriate for residents (as opposed to students), only 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.

How it will be surveyed
- Review of learning experience descriptions.
- Discussion with residents, preceptors, and RPD.

3.3 Development Plan

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

Guidance
- 3.3: Residents' development plans are high level summaries of resident's performance and progress throughout the program. Development plans also support resident's practice interests, career development, and resident well-being and resilience and may include progress towards completion of program requirements if not tracked elsewhere. Development plans include three required components:

- Resident documented self-reflection and self-evaluation: The self-reflection component includes, but is not limited to, documented reflection by the resident on career goals, practice interests, and well-being and resilience. The self-evaluation component includes self-evaluation on the resident's skill level related to the program's competency areas.
- RPD documented assessment of the resident's strengths and opportunities for improvement relative to the program's competency areas, goals, and objectives; progress towards achievement of objectives for the residency (ACHR) and all other completion requirements of the program; and analysis of the effectiveness of the previous quarter's changes.
- RPD documented planned changes to the resident's residency program for the upcoming quarter.
- 3.3.a:
  - Resident self-assessment includes both self-reflection and self-evaluation. Self-reflection is defined as thinking about one's self, including one's behavior, values, knowledge, and growth opportunities. Residents document self-reflection on career goals, areas of clinical interest, personal strengths and opportunities for improvement, and stress management strategies as part of the initial self-assessment. Self-evaluation is comparing one's performance to a benchmark. Residents will compare their current skills to each competency area and identify specific areas of strength and specific areas that the resident feels are the highest opportunities for growth.
  - Residents document their initial self-assessment on the Entering Resident Self Assessment Form and upload in PharmAcademic™. Programs can require residents to complete a program-specific self-assessment in addition to the Entering Resident Self-Assessment Form.

How it will be surveyed
- 3.3.a: Review of Entering Resident Self-Assessment Form.

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

    3.3.b.1   The initial development plan is based on the results of the resident's initial self-assessment and the RPD's assessment of resident's knowledge and skills related to the program's required competency areas.

    3.3.b.2   The RPD or designee documents adjustments to the program for the resident in the initial plan.

3.3.c   The RPD or designee finalizes the resident's initial development plan and shares with preceptors in PharmAcademic™ within 30 days from the start of the residency.

Guidance
- 3.3.b.1 is a Critical Factor (see Glossary for definition of "Critical Factor").
- 3.3.b: The development plan may be documented on the same form as the resident's self-assessment in PharmAcademic™.
- 3.3.b.2:
  - Adjustments to the plan are based on resident's strengths and opportunities for improvement relative the programs competency areas, practice interests, and career goals.
  - Documented advice to the resident is not an adjustment to the program. An adjustment is a change from the baseline program structure for a specific resident. Following are some examples of program adjustments: Adding an additional presentation and practice time with the preceptor for a resident who considers their presentation skills as a weakness;

moving a critical care learning experience to the first quarter for a resident who is interested in pursuing a PGY2 in critical care; eliminating components of orientation for a resident who was a former pharmacy intern; adding hands-on sterile compounding training for one who has no prior experience.

How it will be surveyed
- Review of initial development plan in PharmAcademic™.
- Review of dates the initial development plan is finalized in PharmAcademic™.

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

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

    3.3.d.1.a   An assessment of their progress on previously identified opportunities for improvement related to the competency areas.

    3.3.d.1.b   Identification of the new strengths and opportunities for improvement related to the competency areas.

    3.3.d.1.c   Changes in their practice interests.

    3.3.d.1.d   Changes in their careers goals immediately post residency.

    3.3.d.1.e   Current assessment of their well-being and resilience.

  3.3.d.2   The RPD or designee reviews the resident's self-assessment and documents the following in each development plan update and discusses with resident:

    3.3.d.2.a   An assessment of progress on previously identified opportunities for improvement related to the competency areas.

    3.3.d.2.b   Identification of new strengths and opportunities for improvement related to the competency areas.

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

    3.3.d.2.d   Adjustments to the program for the resident for the upcoming quarter (or 90 days).

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

Guidance
- 3.3.d.2.a and 3.3.d.2.d are Critical Factors (see Glossary for definition of "Critical Factor").
- 3.3.d:

- o Update to the resident self-assessment and development plan are finalized and shared through PharmAcademic™.
  - o The due date is from the start of the residency, <u>not</u> the date of the last documented plan. Development plans not documented and finalized within 30 days of the due date are considered to be late. For example, for programs where resident start date is July 1st, updates to the development plan are to be completed by the end of October, January, and April.
  - o For non-traditional programs, the timing for updates to the development plan, is based on 90 days of resident training time (e.g., If the schedule for non-traditional residents is alternating 1 month of work with 1 month of residency training, development plans would be due every 180 days).
- 3.3.d.1.e: See Well-being and Resilience Resource.
- 3.3.d.1.a, 3.3.d.1.b: Commonly identified opportunities for improvement from residents are tied to the program's competency areas and may include time management, prioritization, clinical acumen, presentations, confidence, assertiveness, and evidence-based medicine knowledge.
- 3.3.d.2: RPD gathers information regarding residents' progress towards completion of program requirements from preceptors involved in residents' training and site coordinators for multiple practice site residencies (as applicable).
- 3.3.d.2.a, 3.3.d.2.b: Discussion with the resident also includes where the RPD's assessment differs from the resident's assessment of 3.3.d.1.a and 3.3.d.1.b.
- 3.3.d.2.d: Adjustments to the plan are based on resident's strengths and opportunities for improvement relative to the program's competency areas, practice interests, and career goals.
- 3.3.e:
  - o The update to the completion requirements can be included in the development plan or in a separate document. If in a separate document, the quarterly update to the completion requirements is documented on the same schedule as the update to the development plan.
  - o RPD gathers information regarding residents' progress towards completion of program requirements from preceptors involved in residents' training and site coordinators for multiple practice site residencies (as applicable).

How it will be surveyed
- 3.3.d: Review of dates resident self-assessment and development plan updates are finalized in PharmAcademic™.
- 3.3.d.1, 3.3.d.2: Review of resident self-assessment and development plan updates in PharmAcademic™.
- 3.3.d.2: Discussion with RPD, residents, and preceptors.
- 3.3.e: Review of completion requirements updates.

3.4   Evaluation of the Resident

    3.4.a.   Formative assessment and feedback

        3.4.a.1   Preceptors provide ongoing verbal feedback to residents about how they are progressing and how they can improve.

            3.4.a.1.a   Feedback is documented for residents not progressing as expected.

        3.4.a.2   Preceptors make appropriate adjustments to learning activities based on residents' progression.

Guidance

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

How it will be surveyed

- Discussion with residents and preceptors.
- Review of documented feedback.

3.4.b. Summative evaluation

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

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

Guidance

- 3.4.b.1 and 3.4.b.1.a are Critical Factors (see Glossary for definition of "Critical Factor").
- 3.4.b: For ASHP-accredited international residency programs, there may be evaluation requirements of respective accrediting bodies as well as those required by ASHP. Other evaluation requirements cannot supplant the evaluation requirements of ASHP, and may occur in addition to ASHP requirements.
- 3.4.b.1: Timeliness is based on the date the summative evaluation is submitted by the preceptor. RPD co-sign date does not impact assessment of evaluation timeliness.
- 3.4.b.1.a: PharmAcademic™ will auto-schedule evaluations for learning experiences greater than 12 weeks based upon the duration and standard requirements.
  - Examples of evaluation schedules for learning experiences greater than 12 weeks.
    - 16 week learning experience: An evaluation will be scheduled at 8 weeks and end of learning experience.
    - 36 week learning experience: Evaluations will be scheduled at 12 weeks, 24 weeks, and at end of learning experience.
    - 40 week learning experience: Evaluations will be scheduled every 70 days (i.e., at end of 10th, 20th, and 30th weeks and at the end of the learning experience).
    - 52 week learning experience: Evaluations will be scheduled every 91 days.

How it will be surveyed

- Review of PharmAcademic™ Evaluation Dashboards and Overall Evaluation Status Reports.
- Evaluations are completed by the due date or within 7 days.

3.4.b.2 The documented summative evaluation includes the extent of the resident's progress toward achievement of assigned objectives based on a defined

rating scale.

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

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

Guidance
3.4.b.2.a is a Critical Factor (see Glossary for definition of "Critical Factor").   3.4.b.2: The program's defined rating scale is documented in the program's manual (e.g., needs improvement, satisfactory progress, achieved, achieved for residency).   3.4.b.2.a: Qualitative written comments: - Are specific and actionable.   - Use criteria related to specific educational objectives.   - Recognize residents' skill development.   - Focus on how residents' may improve their performance.   - See examples on ASHP website.
How it will be surveyed
Review of preceptors' summative evaluations of residents in PharmAcademic™.

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

Guidance
- If multiple preceptors, one preceptor is identified as the primary preceptor. All preceptors who have significant interactions with residents in a learning experience are to be listed as preceptors in PharmAcademic™.   - Programs determine if each preceptor documents input in PharmAcademic™ or if learning experience preceptors will provide verbal or written input to the primary preceptor for documentation of the evaluation in PharmAcademic™.   - The primary preceptor seeks consensus of preceptors to determine final ratings.
How it will be surveyed
- Review of summative evaluations.   - Discussion with preceptors and residents.

3.5   Evaluation of the Preceptor and Learning Experience

    3.5.a   Residents document and discuss an evaluation of each preceptor by the end of the learning experience.

Guidance
- All preceptors who have significant interactions with residents in a learning experience are to be listed as preceptors in PharmAcademic™ and evaluated by residents.   - For orientation and staffing learning experiences, only the primary preceptor is required to be evaluated.
How it will be surveyed
- Review of residents' evaluations of preceptors.   - Review of PharmAcademic™ Evaluation Dashboards and Overall Evaluation Status Reports.   - Discussion with preceptors and residents.   - Evaluations are completed by the due date or within 7 days.

3.5.b   Residents document and discuss an evaluation of each learning experience by the end of the learning experience.

3.5.b.1   For learning experiences greater than twelve weeks in duration, a learning experience evaluation is completed at the midpoint and at the end of the learning experience.

Guidance
• 3.5.b: PharmAcademic^{TM} will auto-schedule evaluations for learning experiences greater than 12 weeks based upon the duration and standard requirements.
How it will be surveyed
• 3.5.b, 3.5.b.1: Evaluations are completed by the due date or within 7 days. • Review of residents' evaluations of learning experiences. • Review of PharmAcademic™ evaluation dashboards and Overall Evaluation Status Reports. • Discussion with preceptors and residents.

Standard 4: Requirements of the Residency Program Director and Preceptors

4.1   Each residency program must have:

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

4.1.a.1   The RPD may delegate, with oversight, administrative duties/activities for the conduct of the residency program to one or more individuals.

4.1.b   A sufficient complement of eligible and fully qualified preceptors to ensure appropriate training, supervision, and guidance to all residents to fulfill the requirements of The Standard.

Guidance

• 4.1.b is a Critical Factor (see Glossary for definition of "Critical Factor").
• 4.1.a: When interim leadership for a residency program is required due to vacancy or leave of absence of the RPD, the director of pharmacy or administrative authority such as the residency advisory committee (RAC), may appoint a pharmacist to serve as Interim RPD.
  ○ The interim appointment is acceptable for a period of no longer than 120 days.
  ○ The organization is not required to notify ASHP, but must change the RPD in PharmAcademic™ to the Interim RPD for continued administration of the residency program.
  ○ By the end of the 120-day period, a new RPD must be appointed if the previous RPD is unable to resume RPD responsibilities.
  ○ Information for a change in RPD must be sent to the Accreditation Services Office (asd@ashp.org) at or before the completion of the 120-day interim appointment. Submitted information must include an updated Academic and Professional Record and an updated Curriculum Vitae.
• 4.1.a.1: The terms used (e.g., residency program coordinator, designee) and definition of roles are determined by, and can vary by, program. The term "coordinator" is an example.

• 4.1.b: 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.
How it will be surveyed

• Review of:
    o RPD's and preceptors' Academic and Professional Record and PharmAcademic™.
    o The residency program's structure documents and learning experience descriptions.
    o Preceptor roster.
    o Residents' evaluations of preceptors and learning experiences.
 • Discussion with RPD, residents, and preceptors.

4.2   RPD Eligibility

    4.2.a   PGY1 RPDs are licensed pharmacists from the practice site who:
- completed an ASHP-accredited PGY1 residency and a minimum of three years of relevant pharmacy practice experience;
  or
- completed ASHP-accredited PGY1 and PGY2 residencies and a minimum of one year of relevant pharmacy practice experience;
  or
- has a minimum of five years of relevant pharmacy practice experience if they have not completed an ASHP-accredited residency.

    4.2.b   PGY2 RPDs are licensed pharmacists from the practice site who:
- completed an ASHP-accredited PGY2 residency in the advanced practice area, and a minimum of three years of additional practice experience in the PGY2 advanced practice area;
  or
- has a minimum of five years of experience in the advanced practice area if they have not completed an ASHP-accredited PGY2 residency in the advanced practice area.

Guidance
• 4.2.a and 4.2.b are Critical Factors (see Glossary for definition of "Critical Factor").   • ASHP-accredited pharmacy residency programs includes residencies in candidate status.   • 4.2.a: PGY1 RPD's pharmacy practice experience is relevant to the practice setting in which the residency is conducted. For PGY1 Community-Based Pharmacy, relevant practice settings are community and ambulatory care practice settings. For PGY1 Managed Care Pharmacy, relevant practice settings are health plan and pharmacy benefit manager practice settings or managed care experience that would be received from practicing in these settings.   • 4.2.b: PGY2 RPD's current pharmacy practice experience is in the same advanced practice area in which the resident is being trained.
How it will be surveyed
• Review of RPD's Academic and Professional Record.

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

    4.3.a   Maintaining BPS certification in the specialty area when certification is offered in that specific advanced area of practice (PGY2 RPDs only).

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

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

4.3.d   Ongoing professional engagement.

4.3.e   Modeling and creating an environment that promotes outstanding professionalism.

4.3.f   Maintaining regular and ongoing responsibilities in the advanced practice area in which they serve as RPDs (PGY2 RPDs only).

Guidance

- 4.3.a, 4.3.b, 4.3.c, 4.3.d, and 4.3.f are Critical Factors (see Glossary for definition of "Critical Factor").
- 4.3.a:
  - Does not apply to PGY1 RPDs or PGY2 RPDs of specialty areas for which there is no Board Certification available, however for PGY2 Internal Medicine residencies, RPD maintains Board Certified Pharmacotherapy Specialist (BCPS) certification.
  - For new specialty areas being recognized by the Board of Pharmacy Specialists® (BPS), relevant board certifications are obtained by January 1 following three offerings of the exam. RPD's who serve as BPS council members for new specialty areas obtain board certification within three years after completion of council member term.
- 4.3b: RPDs demonstrate contribution to practice by documenting at least one example from the following categories (Academic and Professional Record), where examples are from the last four years of practice:
  - Contribution to the development of clinical or operational policies/guidelines/protocols.
    or
  - Contribution to the creation/implementation of a new clinical or operational service.
    or
  - Contribution to an existing service improvement.
    or
  - In-services or presentations to pharmacy staff or other health professionals at organization. This can be at least 3 different inservices/presentations given in the past 4 years, OR a single inservice/presentation given at least annually within the past 4 years.
    or
  - Contribution to the maintenance and development of residency policies.
- 4.3.c: Appointments to drug policy and other committees of the organization or enterprise (e.g., practice setting, college of pharmacy, independent pharmacy) – does not include membership on Residency Advisory Committee (RAC) or other residency-related committees (Academic and Professional Record).
- 4.3.d: Role modeling ongoing professional engagement is demonstrated by documenting at least 3 <u>types</u> of ongoing professional engagement (Academic and Professional Record).
  - Examples are from the last four years of practice with the exception of formal recognition of professional excellence over a career, which is considered a lifetime achievement award. Examples that constitute Lifetime Achievement include: Fellow status for a <u>national</u> organization or Pharmacist of the Year recognition at state/regional level.
  - Examples are from the last four years of practice and occurred after pharmacist licensure obtained and, if applicable, residency training completed. Completion of a teaching certificate program is the only exception, as it could be obtained during residency training.
  - Types of professional engagement include:
    - Formal recognition of professional excellence over a career (e.g., fellow status for a national organization or pharmacist of the year recognition at state or regional level).

- Primary preceptor for pharmacy APPE/IPPE students (does not include precepting residents).
- Classroom/lab teaching experiences for healthcare students (does not include lectures/topic discussions provided to pharmacy IPPE/APPE students as part of their learning experience at the site).
- Service (beyond membership) in national, state, and/or local professional associations.
- Presentations or posters at local, regional, and/or national professional meetings (co-authored posters with students/residents are acceptable).
- Completion of a teaching certificate program.
- Providing preceptor development to other preceptors at the site.
- Evaluator at state/regional residency conferences; poster evaluator at professional meetings; and/or evaluator at other local/regional/state/national meetings; CV reviewer/mock interviewer for local/regional/state/national organizations; and/or ASHP RPD Mentor (RPD only).
- Publications in peer-reviewed journals or chapters in textbooks.
- Formal reviewer of submitted grants or manuscripts.
- Participant in the provision of wellness program(s), health fair(s), health-related consumer education class(es), and/or employee wellness/disease prevention program(s).
- Community service related to professional practice (e.g., free clinic, medical mission trip).
- Professional consultation to other health care facilities or professional organizations (e.g., invited thought leader for an outside organization, mock surveyor, or practitioner surveyor).
- Awards or recognitions at the organization or higher level for patient care, quality, or teaching excellence.
- 4.3.e: The program director models and creates an environment that promotes outstanding professionalism (e.g., environment free from harassment and bullying). Adapted from ACGME Common Requirements.

How it will be surveyed
- Review of RPD's Academic and Professional Record (4.3.a, b, c, d).
- Discussion with RPD.
- Discussion with RPD, Residents, and Preceptors (4.3.e).

4.4   Program Oversight

   4.4.a   A committee(s) is established to guide all elements of the residency program.

        4.4.a.1   Committee(s) meets at least quarterly.

        4.4.a.2   Discussion and decisions of the committee(s) are documented.

   4.4.b   The committee(s) engage in an ongoing process of assessment of the residency program.

        4.4.b.1 A formal program evaluation is conducted annually and includes:

             4.4.b.1.a   Assessment of methods for recruitment.

             4.4.b.1.b   End-of-the year input from residents who complete the program.

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4.4.b.1.c   Input from resident evaluations of preceptors and learning experiences.

4.4.b.1.d   Input from preceptors related to continuous improvement.

4.4.b.1.e   Documentation of program improvement opportunities and plans for changes to the program.

4.4.b.2. Improvements identified through the assessment process are implemented.

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Guidance

- 4.4.a:
  - Oversight of the residency program can be accomplished by a single committee (e.g., residency advisory committee), or for sites/organizations with multiple programs, a combination of committees may be used. If an oversight committee is used to make global decisions for all programs at a site/organization, a mechanism is in place to manage program-level decisions and resident progress.
  - Committee membership includes but is not limited to RPD(s), preceptors, and as applicable, pharmacy leaders. For multiple practice site residencies, site coordinators are also included as members.
  - Elements of the program include but are not limited to recruitment and selection of residents; program requirements and policies; structure, design and conduct of the residency program; and, annual program assessment.
- 4.4.b: Examples of ongoing program assessment may include discussion of program improvement opportunities, discussion of applicant selection process outcomes, review of learning experiences, and review of residents' evaluations of preceptors and learning experiences.
- 4.4.b.1.a: International programs are exempt from meeting this Standard item. During surveys, 'N/A' should be indicated on the pre-survey questionnaire for international programs.
- 4.4.b.1.b: Input includes how effectively the program structure facilitated achievement of the objectives.
- 4.4.b.1.d: When all preceptors are not part of the committee, a process is in place to solicit input from all preceptors (e.g., a survey).

How it will be surveyed

- Review of:
  - Documentation of program improvement opportunities and plans for changes to the program.
  - Documented discussions and decisions.
- Discussion with RPD and preceptors about the program's continuous quality improvement efforts.

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4.4.c   Appointment and Reappointment of Residency Program Preceptors

4.4.c.1   Criteria for preceptor appointment and reappointment are documented.

4.4.c.2   Preceptor compliance with reappointment criteria is reviewed at least every 4 years.

4.4.c.3   Preceptor appointment and reappointment decisions are documented.

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Guidance

- 4.4.c: Process for appointment and selection of preceptors is inclusive of all pharmacists within the organization that are interested in precepting and serve in a position that aligns with the structure and learning experiences of the program.
- 4.4.c.1:
  - The RPD creates or contributes to the appointment and reappointment process, including development of criteria and approval of the program's preceptors.
  - Criteria should include verification of preceptors' eligibility (Standard 4.5- Preceptor Eligibility) and qualifications (Standard 4.6 - Preceptor Qualifications), along with program or organization-specific criteria (e.g., attendance at a specific number of preceptor or committee meetings, attendance at resident presentations, completing an annual self-assessment, presenting preceptor development topics, updating Academic and Professional record form, or others defined by the program). Criteria may also include an evaluation of preceptor skills (e.g. resident feedback, review of evaluations in PharmAcademic™, review of documentation of criteria-based feedback on summative evaluations).
- 4.4.c.2: Preceptor appointment terms may not exceed 4 years.
- 4.4.c.3: Examples of documentation may include committee meeting minutes, spreadsheet, letter of appointment/reappointment, tracking tool.

How it will be surveyed
- Review of documented criteria for appointment and reappointment.
- Review of documented appointment decisions.
- Discussion with RPD about the appointment/reappointment process.

4.4.d   A preceptor development plan is created and implemented to support the ongoing refinement of preceptor skills.

4.4.d.1   A schedule of activities for each residency year is documented.

Guidance
- Multiple programs within an organization may partner to create and utilize a single preceptor development plan.
- Required participation of preceptors in development activities is defined (e.g., must complete x-number of development activities).
- Areas to consider when creating content for preceptor development may include assessment of preceptor skills, review of residents' evaluations of preceptors, peer review, preceptors' self-assessments, and/or performance reviews. Preceptor development activities focus on increasing knowledge and skills that can be applied to effectively precepting residents regardless of practice setting (e.g., methods for providing effective feedback, understanding and applying the residency accreditation standard, setting clear expectations, instilling professionalism and confidence, tips for precepting a successful resident research project) rather than activities solely centered around improving or increasing clinical knowledge (e.g., reviewing practice guidelines, completing continuing education on a clinical topic).
- Consider education to the preceptors on recognizing burnout syndrome, the risks, and mitigation strategies for residents. Resources available on the ASHP website can be found here: https://www.ashp.org/wellbeing

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

4.5   Pharmacist Preceptors' Eligibility

4.5.a   PGY1 Preceptors must be licensed pharmacists who:
- have completed an ASHP-accredited PGY1 residency program followed by a minimum of one year of pharmacy practice experience in the area precepted; *or*
- have completed an ASHP-accredited PGY1 residency program followed by an ASHP-accredited PGY2 residency and a minimum of six months of pharmacy practice experience in the area precepted; *or*
- have three or more years of pharmacy practice experience in the area precepted if they have not completed an ASHP-accredited residency program.

Guidance
- 4.5.a is a Critical Factor (see Glossary for definition of "Critical Factor").
- ASHP-accredited pharmacy residency programs includes residencies in candidate status.

How it will be surveyed:
- Review of preceptor roster.
- Review of preceptors' academic and professional record forms.

4.5.b   PGY2 Preceptors must be licensed pharmacists who:
- have completed an ASHP-accredited PGY2 residency program followed by a minimum one-year of pharmacy practice experience in the area precepted. OR
- have three or more years of pharmacy practice experience in the area precepted if they have not completed an ASHP-accredited PGY2 residency program.

Guidance
- 4.5.b is a Critical Factor (see Glossary for definition of "Critical Factor").
- ASHP-accredited pharmacy residency programs includes residencies in candidate status.
- Preceptor's PGY2 residency training is in the same advanced practice area as the area precepted.
- Preceptor's pharmacy practice experience is in the same advanced practice area in which the resident is being trained.

How it will be surveyed:
- Review of preceptor roster.
- Review of preceptors' academic and professional record forms.

4.6   Preceptors' Qualifications: Preceptors must demonstrate the ability to precept residents' learning experiences as evidenced by:

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

Guidance
- 4.6.a is a Critical Factor (see Glossary for definition of "Critical Factor").
Preceptors demonstrate at least one example of the following related to the area of pharmacy practice precepted (Academic and Professional Record):
- Any active BPS Certification(s) (type(s) and expiration date).
- Post-graduate fellowship in the advanced practice area or advanced degrees related to practice area beyond entry level degree (e.g., MS, MBA, MHA, PhD).
- Completion of Pharmacy Leadership Academy (DPLA).
- Pharmacy-related certification in the area precepted recognized by Council on Credentialing in Pharmacy (CCP): *Note: This does not include Basic Life Support (BLS), Advanced Cardiac Life*

Support (ACLS), or Pediatric Advanced Life Support (PALS).
- For non-direct patient care areas, nationally-recognized certification in the area precepted. Examples: Certified Professional in Healthcare Information and Management Systems (CPHIMS) or Medical Writer Certified (MWC).
- Certificate of completion in the area precepted (minimum 14.5 contact hours or equivalent college credit) from an ACPE-accredited certificate program or accredited college/university. Certificate of completion obtained or renewed in last four years.
- Privileging granted by preceptor's current organization that meets the following criteria:
  o Includes peer review as part of the renewal process.
  o Only utilized for advanced practice. Privileging for areas considered to be part of the normal scope of practice for pharmacists such as therapeutic substitution protocols or pharmacokinetic protocols will not meet the criteria for 4.6.a.
  o If privileging exists for other allied health professionals at the organization, pharmacist privileging must follow the same process.
- Subject matter expertise as demonstrated by:
  o Completion of PGY2 residency training in the area precepted PLUS at least 2 years of practice experience in the area precepted.
    or
  o Completion of PGY1 residency training PLUS at least 4 years of practice experience in the area precepted.
    or
  o PGY2 residency training NOT in the area precepted PLUS at least 4 years of practice experience in the area precepted.
    or
  o At least 5 years of practice experience in the area precepted.

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

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

Guidance
- 4.6.b is a Critical Factor (see Glossary for definition of "Critical Factor").
Preceptors demonstrate contribution to pharmacy practice in the area precepted by documenting at least one example that meets the following criteria (Academic and Professional Record). Examples are from the last four years of practice and occurred after preceptor obtained pharmacist licensure and after completion of residency training, if applicable.
- Contribution to the development of clinical or operational policies/guidelines/protocols.
  or
- Contribution to the creation/implementation of a new clinical or operational service.
  or
- Contribution to an existing service improvement.
  or
- Appointments to drug policy and other committees of the organization or enterprise (e.g., practice setting, college of pharmacy, independent pharmacy) – does not include membership on Residency Advisory Committee (RAC) or other residency-related committees.
  or

• In-services or presentations to pharmacy staff or other health professionals at organizations. This can be at least 3 different inservices/presentations given in the past 4 years, OR a single inservice/presentation given at least annually within the past 4 years.
How it will be surveyed
Review of preceptors' academic and professional record forms.

4.6.c   Role modeling ongoing professional engagement.

Guidance

4.6.c: Role modeling ongoing professional engagement is demonstrated by documenting at least 3 types of ongoing professional engagement (Academic and Professional Record).
 	
• Examples are from the last four years of practice with the exception of formal recognition of professional excellence over a career, which is considered a lifetime achievement award. Examples that constitute Lifetime Achievement include: Fellow status for a national organization or *Pharmacist of the Year* recognition at state/regional level.
• Examples are from the last four years of practice and occurred after pharmacist licensure obtained and, if applicable, residency training completed. Completion of a teaching certificate program is the only exception, as it could be obtained during residency training.
• Types of professional engagement include:
   o Formal recognition of professional excellence over a career (e.g., fellow status for a national organization or pharmacist of the year recognition at state or regional level).
   o Primary preceptor for pharmacy APPE/IPPE students (does not include precepting residents).
   o Classroom/lab teaching experiences for healthcare students (does not include lectures/topic discussions provided to pharmacy IPPE/APPE students as part of their learning experience at the site).
   o Service (beyond membership) in national, state, and/or local professional associations.
   o Presentations or posters at local, regional, and/or national professional meetings (co-authored posters with students/residents are acceptable).
   o Completion of a teaching certificate program.
   o Providing preceptor development to other preceptors at the site.
   o Evaluator at state/regional residency conferences; poster evaluator at professional meetings; and/or evaluator at other local/regional/state/national meetings; CV reviewer/mock interviewer for local/regional/state/national organizations.
   o Publications in peer-reviewed journals or chapters in textbooks.
   o Formal reviewer of submitted grants or manuscripts.
   o Participant in the provision of a wellness program(s), health fair(s), health-related consumer education class(es), and/or employee wellness/disease prevention program(s).
   o Community service related to professional practice (e.g., free clinic, medical mission trip).
   o Professional consultation to other health care facilities or professional organizations (e.g., invited thought leader for an outside organization, mock surveyor, or practitioner surveyor).
   o Awards or recognitions at the organization or higher level for patient care, quality, or teaching excellence.

How it will be surveyed:
• Review of preceptors' academic and professional record forms.

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

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

4.7   Preceptors maintain an active practice and ongoing responsibilities for the area in which they serve as preceptors.

   4.7.a   Preceptors actively participate and guide learning when precepting residents.

Guidance
- 4.7 and 4.7.a are Critical Factors (see Glossary for definition of "Critical Factor").
- 4.7: Preceptor may be part-time and/or at a remote location but must be actively engaged.
- 4.7a:
  - If more than one preceptor is involved in a learning experience, one preceptor is designated as the primary preceptor, maintains continuity of the learning experience, and is accountable for global oversight of the resident's progression over the course of the learning experience. Methods for communication among preceptors and providing coordinated feedback to the resident are utilized.
  - Preceptors engaged in the training of residents during a learning experience (i.e., team-precepted experiences) should be designated as preceptors for the experience (may not be applicable for orientation or staffing learning experiences).
  - A PGY2 resident may serve as a preceptor for a PGY1 learning experience only if a qualified preceptor is also assigned to the experience.

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

4.8   Non-Pharmacist preceptors (e.g., physicians, physician assistants, certified advanced practice providers) may be utilized as preceptors per the following requirements:

   4.8.a   Direct patient care learning experiences are scheduled after the RPD and preceptors assess and determine that the resident is ready for independent practice.

      4.8.a.1   Readiness for independent practice is documented in the resident's development plan.

   4.8.b   The RPD, designee, or other pharmacist preceptor works closely with the non-pharmacist preceptor to select the educational objectives and activities for the learning experience.

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

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

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

How it will be surveyed
- Review of learning experience descriptions precepted by non-pharmacist preceptors.
- Review of residents' schedules.
- Review of residents' development plans.
- Interview of residents and non-pharmacist preceptors.

Standard 5: Pharmacy Services

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

5.1 Pharmacy Leadership

    5.1.a   Pharmacy Scope and Services

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

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

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

5.1.a.3.a   Pharmacy plan is communicated to all departmental staff and reported out to appropriate organizational leaders.

5.1.a.4   Pharmacy leaders hold decision-making roles in the planning and management of medication-use systems.

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

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

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

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

Guidance

- 5.1.a.5 and 5.1.a.7 are Critical Factors (see Glossary for definition of "Critical Factor").
- 5.1.a.1: Scope of services includes hours of operation and a description of distributive/operational and clinical services provided by the pharmacy.
- 5.1.a.2: Reporting structure may be indirect provided that pharmacy leadership is collaboratively involved in the planning of medication-related initiatives.
- 5.1.a.3:
  o Plan that includes short-term (1 year) and long-term (3 years) goals.
  o Pharmacy plan is communicated to all departmental staff and reported out to appropriate organizational leaders.
- 5.1.a.4: Examples of decision-making roles for Pharmacy leaders:
  o Participate in the planning of patient care services (e.g., if planning a new clinical service, pharmacy is involved from the beginning).
  o Collaborate with other healthcare professionals to ensure safe medication-use systems (e.g., pharmacy is involved in reviewing overrides and controlling the drug library for smart pump use, reviewing medication errors regularly and developing retraining).
  o Ensure pharmacy is engaged in decision-making on corporate/system-wide, organization-level, and local committees that oversee medication safety and optimal drug therapy (e.g., Pharmacy and Therapeutics, Quality, Medication Safety, Information Technology, Investigational Review Board, Clinical Services/Planning Committees).
- 5.1.a.5:
  o Pharmacy services at the practice site extend to all patients for which medications are dispensed, administered, and monitored.
  o The scope, quality, and consistency of services provided aligns with best practices.
- 5.1.a. 6:
  o Pharmacy personnel practice at the maximum level that their state or jurisdiction allows.
  o Examples of a high level of practice for technicians include:
    ▪ Tech-check-tech.
    ▪ Immunizations.
    ▪ Medication histories.
- 5.1.a.7: All sites use pharmacist-managed protocols and/or collaborative practice agreements and/or statewide protocols, consistent with applicable laws and regulations.
  o For direct patient care PGY2 programs, pharmacists use pharmacist-managed protocols and/or collaborative practice agreements in the area of practice in which the PGY2 residency program is conducted.

> - o N/A for MANAGED CARE unless the resident spends time in an area where providers utilize collaborative practice agreements.
> - o Pharmacist-managed protocols and collaborative practice agreements include any practice where pharmacists are independently managing medication therapy (i.e., pharmacists are not required to contact the prescriber to initiate, modify, and/or discontinue therapy in individual patients).
> - o State-wide protocols may include hormonal contraception, HIV prep-pack, TB screening, test and treat, immunizations, and naloxone, among others.
> - 5.1.a.8:
> - o For pharmacies that are part of a health-system, there is coordination across all areas where pharmacy services are provided throughout the organization (e.g., acute care, ambulatory care, outpatient pharmacy, home health, infusion centers, population health).

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

Guidance
- If external accreditation is not feasible, practice sites conduct self-assessments of medication-use practices against established and recognized accreditation standards or best practice guidelines relevant to the practice environment.
- Examples of established/recognized accreditation standards or best practice guidelines include but are not limited to ACHC, URAC, NCQA, TJC, DNV, and/or JCI (Joint Commission International).

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

5.1.c.1   Ensuring recruitment of pharmacy personnel includes methods that are consistent with sponsoring institution's mission and strategic aims.

5.1.c.2   Providing resources for ongoing professional development for pharmacists and pharmacy technicians.

5.1.c.3   Ensuring the competence of pharmacists is validated through an ongoing, formalized process.

5.1.c.4   Ensuring the competence of pharmacy technicians performing specialized functions is validated through an ongoing, formalized process.

5.1.c.5   Providing resources for assessing and supporting staff well-being and resilience.

5.1.c.6   Providing program administration time to the residency program director (RPD) to support residency training.

5.1.c.7   Providing support for the ongoing management and improvement of the residency program(s).

Guidance
- 5.1.c.1: International programs are exempt from meeting this standard item. During surveys, 'N/A' should be indicated on the pre-survey questionnaire for international programs.

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

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

5.1.d.1   Access to appropriate resources necessary to provide the scope of services.

5.1.d.2   Space to facilitate safe and efficient medication-use processes.

5.1.d.3   Space to provide confidential patient care services and discussions with patients/family members/caregivers and members of the healthcare team.

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

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

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

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

        5.2.b.1   Management of secure storage for all medications.

        5.2.b.2   Identification, storage and labeling of high risk/high alert medications.

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

        5.2.b.4   Management of medications in automated systems.

        5.2.b.5   Management of hazardous medications.

        5.2.b.6   Procedures to ensure that all medications are dispensed in a ready-to-administer dose.

        5.2.b.7   Management of pharmaceutical waste.

    5.2.c   Medication-use policies are followed.

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

Guidance:
- 5.2.a and 5.2.b are Critical Factors (see Glossary for definition of "Critical Factor").
- 5.2a, 5.2.b.1-5.2.b.7: N/A for MANAGED CARE unless the resident spends time in an area where there is medication storage, preparation, dispensing or administration.
- 5.2.a:
  - Encompasses areas both internal and external to the pharmacy such as pharmacy satellites, medication rooms on nursing units, infusion centers, the emergency department, ambulatory care clinics, and procedural areas; also included are processes for code carts, emergency kits, and any outsourced medications.
  - Pharmacy leads efforts to optimize safe medication-use systems when collaborating with other disciplines.
- 5.2.b: Policies include the following as applicable to the practice environment:
  - 5.2.b.1: Storage
    - Policies address the security of medications in all storage areas (e.g., medication rooms, satellites, clinics, ambulatory care areas, procedural areas).
  - 5.2.b.2: High risk/High alert
    - Maintains a defined list of high risk/high alert medications.
    - For pharmacies that prepare pediatric medications:
      - The process for oral and injectable extemporaneously prepared products is documented and includes appropriate safety measures (e.g., if batching of pediatric doses is combined with adult batching, they are prepared at the end of the run; in different hoods or preparation areas).
  - 5.2.b.3: Examples of medications that may have special requirements:
    - Investigational drugs.

- Controlled substances handling/diversion monitoring.
- Medications with Risk Evaluation and Mitigation Strategies requirements (REMS).
- Limited distribution drugs (LDD) and/or medications that have specific regulatory, compliance or reporting requirements.
  - 5.2.b.4: Automated systems
    - Includes automated dispensing cabinets, automated filling machines/robots.
    - Systems to ensure patient safety when medications are dispensed without prospective review:
      - Criteria and approval process for determining which medications may be overridden or auto-verified is documented; includes frequency of review. [N/A for COMMUNITY, MANAGED CARE]
      - Process and frequency of pharmacy review of medication override reports is documented. [N/A for COMMUNITY, MANAGED CARE]
    - Process for resolving discrepancies between actual inventory versus the stated inventory is documented. N/A for MANAGED CARE unless the resident spends time in an area where there is medication storage, preparation, dispensing or administration.
  - 5.2.b.5: Hazardous medications
    - Maintains a defined list of hazardous medications.
    - Procedures to ensure medications are received, stored, prepared, transported, administered, and wasted/disposed of in a manner to promote safe work practices and minimize occupational exposure.
  - 5.2.b.6: Ready-to-administer form
    - Process for identifying and formally evaluating medications that are not provided in a ready-to-administer dose to ensure appropriate safety measures are established (e.g., tablet splitting, oral liquid doses, IV admixtures).
    - Community or outpatient pharmacy prescriptions that are dispensed for self-administration by patients are prepared in a form that minimizes risk of error and the need for manipulation by patients/caregivers.
    - Ensuring patient has needed accessories with certain products like insulin pen needles when a pen is prescribed, correct glucose meter strips for machine purchased, provision of oral syringes and tablet splitters.
    - Exceptions include but are not limited to multi-dose vials (e.g., naloxone and insulin), injections that need to be reconstituted at time of use due to stability (e.g., glucagon).
  - 5.2.7.b: Includes all pharmaceutical waste (e.g., controlled substances, hazardous medications or other regulated materials).
- 5.2.c: All policies in 5.2.b.1-7 are followed by personnel impacted by the scope of the policy.
- 5.2.d: Policies are reviewed routinely and at an interval established by pharmacy, but at least every three (3) years.

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

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

5.2.e.2 Pharmacy has a leadership role in efforts to evaluate and ensure compliance with established best practices/benchmarks.

5.2.f Pharmacy has a leadership role in the medication safety program, including the routine collection, analysis, and implementation of action plans related to medication safety events.

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

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

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

5.2.h   Pharmacy develops and manages an evidence-based formulary.

Guidance:
- 5.2.e, 5.2.f, 5.2.g, 5.2.g.1 and 5.2.g.2 are Critical Factors (see Glossary for definition of "Critical Factor").
- 5.2.e: Technology and automation is used to optimize medication safety and efficiency in the medication-use process (e.g., automated dispensing cabinets (ADCs) are profiled; bar code technology used in stocking/removing/restocking; pharmacy management of libraries for smart infusion pumps; bar code technology used in dispensing; CQI for robotics, pill counters; central fill; automated prescription pick up).
  - Measures are in place to ensure safe medication use if technology isn't optimized to best practice level (e.g., criteria for medications that may not be overridden, such as high risk/high alert, medications requiring weight-based dosing, hard stops for medication allergies or serious drug-drug interactions that require further documentation, or other measures as applicable to the practice site).
- 5.2.e.1:
  - The number of different information system and technology platforms are streamlined in an effort to avoid multiple sources of patient information and minimize potential errors in the documentation and communication of patient information during care transitions.
  - Technologies support connectivity and/or interoperability of information systems.
  - Examples of connectivity and/or interoperability of information systems includes, but is not limited to:
    - Smart pumps interfaced with electronic health record.
    - Computerized physician order-entry (CPOE) throughout the organization.
    - Managed care, ambulatory care, and community settings - examples include:
      - information systems that can generation identification of patients that need therapy optimized.
      - formulary integration across systems.
      - online prior-authorizations.
      - medication synchronization.
      - targeted clinical interventions.
- 5.2.e.2:
  - May be performed in collaboration with other disciplines.
  - Examples include, but are not limited to review of:
    - bar-code medication administration compliance rates (BCMA)
    - automated dispensing cabinet (ADC) override rates
    - smart pump compliance rates
    - misfill rates
    - drug utilization review (DUR) reports
- 5.2.f: Medication Safety

- o Should be performed in collaboration with other disciplines as applicable to the practice environment.
  - o Processes are established and information systems developed for reporting, analyzing, and monitoring of events.
  - o Action plans and process changes are implemented based on the analysis of the data collected and analyzed.
  - o Reporting rates are reviewed.
  - o Results are reported out to appropriate department and organizational leaders/oversight committee.
- 5.2.g: For direct patient care PGY2 programs, pharmacists participate in the development of treatment protocols, critical pathways, order sets, and other systems approaches involving medications for patients in the area of practice in which the PGY2 residency program is conducted.
- 5.2.g.1: Continuous quality improvement (CQI) process should include assessment of effectiveness, outcomes and use of treatment protocols, medication-use guidelines, and/or other systematic approaches to disease management. Examples include but are not limited to:
  - o Routine performance of medication-use evaluations to assess the use of, and effectiveness of protocols.
  - o Acceptance rates of recommendations provided to other healthcare providers.
  - o Capture rate of eligible patients.
  - o Consistent use of protocols, etc. by all pharmacists.
  - o Patient access to naloxone and/or other medications that can be "prescribed per protocol" via state-based protocols.Percent of patients at established therapeutic goals for A1c, blood pressure, lipid profile.
  - o Antimicrobial stewardship program reporting metrics.
  - o Proportion of days covered (PDC).
  - o Impact on medication compliance/adherence as a result of medication synchronization programs.
  - o Analysis of antimicrobial stewardship data; reversal agent use; others as applicable to the practice environment.
- 5.2.g.2: Appropriate actions based on results are implemented.
- 5.2.h:
  - o [N/A for COMMUNITY]
  - o The process for formulary management accounts for all care areas where medications are administered to patients (e.g., clinics, infusion centers, inpatient).
  - o Formularies may be developed at the local, system, or national level of the organization.

5.3   Patient-Centered Care

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

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

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

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

5.3.a.4   Pharmacists collaborate with other health professionals to provide team-based care.

5.3.a.5 Pharmacists collaborate with the patient, family, and caregivers to manage patient care medication-related needs and education.

5.3.a.6 Pharmacists and pharmacy technicians are involved in medication-related transitions of care activities.

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

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

Guidance
- 5.3.a.1, 5.3.a.3, and 5.3.a.4 are Critical Factors (see Glossary for definition of "Critical Factor").
- 5.3.a.1:
- Comprehensive care includes identification of all medication-related problems including appropriate treatment; appropriate indication, dose and regimen; effectiveness; safety; and, adherence.
  - Encompasses both frequency of review and comprehensiveness.
- 5.3.a.2: Pharmacy has processes in place to provide population health services.
  - Clinical Decision Support (CDS) includes clinical monitoring tools built into the electronic health record (EHR) to determine prioritization of patients, use of targeted patient lists to determine the type of intervention needed.
  - CDS may include:
    - Artificial intelligence and machine learning tools.
    - Pharmacoadherence tools.
    - Tools or platforms to identify gaps in care (e.g., Medication Therapy Management (MTM) platform -Targeted Medication Review (TMR)).
    - Tools to access formulary guidelines.
- 5.3.a.3: Includes State-wide protocols.
- 5.3.a.4: For direct patient care PGY2 programs, pharmacists are essential members of interdisciplinary teams in the patient care areas in which the PGY2 residency program is conducted.
- 5.3.a.4:
  - Examples include:
  - Intra-professional collaboration with other pharmacists.
  - Daily or Discharge rounds.
  - Via various synchronous and asynchronous virtual and telecommunication methods for targeted interventions in the community pharmacy setting.
  - Recognizing when a patient needs a higher level of care/triaging.
  - Interaction and collaboration with other healthcare professionals also occurs during the provision of educational programs about medications, medication therapy, health, and other related matters to other healthcare providers.
- 5.3.a.5:
  - Pharmacists: (Examples as applicable to practice environment)
  - Provide educational programs about medications, medication therapy management, health, and other related matters to patients, family, and caregivers.
  - Provide patient counseling and education services on medication initiation; medication changes; for high-risk medications and high-risk patients; and, assist patients with self-care decisions (e.g., OTC), as applicable.
  - Perform financial assessments and/or refer or facilitate enrollment of patients in Patient Assistance Programs (PAP).

- - Care is provided in a way that is coordinated and convenient to the patient and caregivers (e.g., virtual visits, telehealth services, patient-provider messaging, face to face in shared medical clinics).
- 5.3.a.6:
  - Pharmacists and pharmacy technicians:
  - Perform medication histories and update medication lists through all care transitions; take appropriate actions and communicate with appropriate members of the healthcare team.
  - Provide patient education.
- 5.3.a.7: Health and wellness services can include but are not limited to:
- Immunizations
- Health screenings
- Wellness visits (falls risk, depression risk, etc.)
- Travel medicine
- Wellness programs including smoking cessation, weight loss, pain management
- Health fairs
- Medication take-back
- Disease prevention patient education classes
- Naloxone education
- MANAGED CARE examples:
  - Weight loss benefits
  - Adherence interventions
  - Predictive analytics
  - Pharmacogenomics
  - Digital therapeutics
  - Immunizations
  - Medication take-back
  - Naloxone
  - Health fairs
  - Smoking cessation and benefits
  - CMRs
- 5.3.a.8: [N/A for MANAGED CARE]
- When 24/7 services aren't provided, pharmacies:
  - Publish the times when pharmacy services are available (e.g., community pharmacy with 9 am – 10 pm hours).
  - Provide access to services remotely (e.g., contracted pharmacy services for prospective order verification and consultative services).
  - Security measures are in place for access to medications during the hours that the pharmacy is closed (e.g., use of ADCs).
    - Access to the physical pharmacy is restricted.

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

5.3.b.1   Pharmacists prospectively design patient-centered care plans.

5.3.b.2   Pharmacists recommend and implement patient-centered care plans.

5.3.b.3   Pharmacists monitor and evaluate the effectiveness of the patient-centered care plan and modify the plan as needed.

5.3.b.4   Pharmacists document patient care recommendations, treatment plans, and

other services in the patient's permanent medical record according to practice setting.

Guidance
- 5.3.b.1, 5.3.b.2, 5.3.b.3, and 5.3.b.4 are Critical Factors (see Glossary for definition of "Critical Factor").

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

- 5.3.b: For direct patient care PGY2 programs, pharmacists provide care that is safe, effective, and individualized to the patient, as described in Standards 5.3.b.1 - 5.3.b.4, for the area of practice in which the PGY2 residency program is conducted.
- 5.3.b.1: As part of the design of safe and effective individualized patient-centered care plans, pharmacists consider the following information as available and appropriate to the practice setting:
  - Collect relevant subjective and objective information.
  - Analyze and assess information based on:
    - complete and current medication lists and medication-use history including prescription and nonprescription medications, herbal products and other dietary supplements, formulary review, and real time benefit check.
    - relevant health data including medical history, health and wellness information, biometric test results, physical assessment findings, pharmacogenomics /pharmacogenetics information.
    - patient lifestyle habits, preferences and beliefs, health and functional goals, and socioeconomic factors that affect access to medication(s) and other aspects of care.
  - Incorporate cultural competence and social determinants of health into development of the care plan and communication with patients/families/caregivers.
  - Address and resolve potential barriers (e.g., literacy, access, language needs).
  - Perform physical assessments, point of care testing, and/or order laboratory tests.
- 5.3.b.2: As part of the implementation of patient-centered care plans, pharmacists:
  - Initiate, modify, discontinue, and/or administer medication therapy as authorized and in accordance with the scope of their practice as defined by state laws, collaborative practice agreements, protocols, and/or practice site policies.
  - Resolve medication-related problems.
- 5.3.b.3: As part of monitoring and evaluation of the effectiveness of the patient-care plan, pharmacists:
  - Ensure appropriate follow-up and reassessment of the patient-care plan for modifications and adjustments to therapy.
  - Assess each medication for appropriateness, effectiveness, safety, and patient adherence.
- 5.3.b.4:
  - Clinical recommendations made by a pharmacist on behalf of the patient, as well as actions taken in accordance with these recommendations, are documented in a permanent manner that makes the information available to all the healthcare professionals caring for the patient.

Glossary of Terms and Acronyms

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

Academy of Managed Care Pharmacy (AMCP): AMCP is the professional association leading the way to help patients get the medications they need at a cost they can afford. AMCP's diverse membership of pharmacists, physicians, nurses, biopharmaceutical professionals, and other stakeholders leverage their specialized expertise in clinical evidence and economics to optimize medication benefit design and population health management to help patients access cost-effective and safe medications and other drug therapies. AMCP members improve the lives of nearly 300 million Americans served by private and public health plans, pharmacy benefit management firms, and emerging care models. Accreditation (for managed care pharmacy residency programs) is granted by ASHP in partnership with AMCP under the *Required Competency Areas, Goals, and Objectives for PGY1 Managed Care Pharmacy Residencies*.

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

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

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

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

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

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

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

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

Designee: An individual designated by the residency program director to perform duties as allowed by The Standard. A designee cannot be a resident in the residency program.

Det Norske Veritas (DNV): DNV is a global independent organization dedicated to safeguarding life, property, and management. DNV Healthcare is a branch of DNV that accredits hospitals and other healthcare organizations.

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

Foreign Pharmacy Graduate Examination Committee (FPGEC) Certification: Certification requirement for graduates of pharmacy schools not located in the United States (U.S.). *Certification ensures that a foreign pharmacist's education meets acceptable requirements as compared to education that* U.S.-*educated pharmacists are expected to have before they practice as licensed pharmacists*. All applicants in the Match who graduated from pharmacy schools outside the U.S. must provide this certification or documentation of pharmacist licensure in the U.S. to register for the Match. This certification is conferred by the National Association of Boards of Pharmacy (NABP) and is required by all 50 states in the U.S., the District of Columbia, Guam, and Puerto Rico before applying for a license from a state board of pharmacy though some states exempt graduates from Canadian pharmacy schools from this requirement. Once FPGEC certification is obtained, each state has different requirements as part of the state's licensure application process. To apply for FPGEC certification, applicants must currently be licensed and/or registered for unrestricted practice of pharmacy in a foreign country or jurisdiction. If the applicant's pharmacy degree was issued after January 1, 2003, the applicant must have completed a minimum five-year pharmacy curriculum at the time of graduation. To obtain FPGEC certification, applicants who meet the eligibility requirements must achieve the minimal acceptable score for the Test of English as a Foreign Language and the Foreign Pharmacy Graduate Equivalency Examination (FPGEE).

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

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

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

Match Phase II: Programs with unfilled positions in Phase I of the Match will offer those positions to unmatched applicants in Phase II of the Match. New programs or positions that receive funding after Phase I of the Match may also be added into Phase II of the Match, and applicants who did not participate in Phase I of the Match may participate in Phase II. All applicants seeking positions after Phase I and all programs with available positions after Phase I submit their Rank Order Lists by the Rank Order List deadline for Phase II of the Match. A second match will be carried out using those Rank Order Lists, and the results of Phase II of the Match will then be distributed.

Medication Use System: Describes the complex process in which a medication reaches the patient and includes prescribing, order processing, dispensing, administration, and patient monitoring.

National Association of Boards of Pharmacy (NABP): NABP is an independent, international, and impartial association that assists its member boards and jurisdictions for the purpose of protecting the

public health. The NABP responsibilities include ensuring the public's health and safety through its pharmacist license transfer and pharmacist competence assessment programs.

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

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

Non-Traditional Residency Programs: Non-traditional residency programs offer residency training to licensed pharmacists and must meet the same accreditation requirements as traditional programs, including providing 52 total weeks of training. Program duration and design is defined by the offering organization. Typically, non-traditional programs are completed within 2-3 years.

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

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

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

Program Operator: The organization (e.g., hospital, college of pharmacy, corporation, federally qualified healthcare center (FQHC), outpatient clinic, or other business entity) that applies for accreditation, and is administratively responsible for compliance with The Standard.

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

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

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

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

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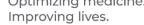
Utilization Review Accreditation Commission (URAC): URAC is a non-profit organization that accredits and provides certifications for many types of healthcare organizations and services including community pharmacies, health plans, infusion pharmacies, mail service pharmacies, and specialty pharmacies.

Approved by the ASHP Board of Directors, April 8, 2022. Developed by the ASHP Commission on Credentialing and in partnership with the following organizations:

This standard replaces the previous ASHP Board of Directors approved Accreditation Standards for Postgraduate Year One (PGY1) Pharmacy Residency Programs (approved September 22, 2016), Postgraduate Year One (PGY1) Community-based Pharmacy Residency Programs (approved January 22, 2016), Postgraduate Year One (PGY1) Managed Care Pharmacy Residency Programs (approved September 23, 2016), and Postgraduate Year Two (PGY2) Pharmacy Residency Programs (approved April 7, 2017). This revision and harmonization of the accreditation standard is effective July 1, 2023.

This ASHP Accreditation Standard and Guidance documentation (previously approved and published for the July 1, 2023 effective date) has subsequently been reviewed and revised. The content now within this documentation replaces the prior version and a *Summary of Changes* document may be referenced on the ASHP website, highlighting the specific revisions made. The Standard and Guidance revisions were approved by the ASHP Commission on Credentialing on March 3, 2024 and endorsed by the ASHP Board of Directors on April 11, 2024. Revisions are effective July 1, 2024.

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