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Postgraduate Year 1 Pharmacy Residency Accreditation Requirements and Challenges

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The residency accreditation process can be a stress-inducing experience to many program directors. In 2014, the postgraduate year 1 (PGY1) pharmacy residency accreditation standards were updated from the previous 2005 version. The new standards were formulated to streamline program requirements with the intention of creating a more transparent accreditation process.[1] The American Society of Health-System Pharmacists (ASHP) is the accrediting body for PGY1 residencies, PGY1 community pharmacy residencies, PGY1 residencies in managed care pharmacy, and PGY2 pharmacy residency programs in advanced practice areas. ASHP provides many resources to help programs to prepare for and navigate through the accreditation process [https://www.ashp.org/Professional-Development/Residency-Information/Residency-Program-Directors]. Additionally, new *Guidance Documents* have been created for the PGY1 residency standards as well as the new competency areas, goals and objectives.[2,3] The guidance documents aim to clarify the expectations of each standard and the manner in which it will be surveyed. However, during site visits and feedback from program directors, some common areas of the standards continue to be challenging for programs.

Recently, ASHP released their bi-annual *Communique'* newsletter for Spring 2016 [https://www.ashp.org/professional-development/residency-information/residency-program-directors/communique-newsletter].[3] The *Communique'* highlights common standards that are cited during accreditation visits. We will review some of these commonly cited standards as well as others that are often noted during site visits as being challenging to programs and provide some tips on how to navigate them.

Standard 3

We will focus on a few selected components of Standard 3 to provide some points to consider. Please note, Standard 3 is fairly in-depth and comprises the bulk of a residency program design. ASHP has developed training materials which are presented at several national meetings and a webinar (available for purchase) that discusses residency program design and conduct (RPDC) which can be utilized by all preceptors in a residency program.

http://elearning.ashp.org/catalog.

Standard 3.1. Program Purpose

Under the most recent 2014 Standards, all programs are required to convert their program purpose statement to the language contained within the standard. Site surveyors reported that 20% of programs were cited during site visits because programs did not use the required purpose statement in all of their program materials. The new statement is as follows:

"PGY1 Program Purpose: PGY1 pharmacy residency programs build on Doctor of Pharmacy (Pharm.D.) education and outcomes to contribute to the development of clinical pharmacists responsible for medication-related care of patients with a wide range of conditions, eligible for board certification, and eligible for postgraduate year two (PGY2) pharmacy residency training."

Tips:
Consider the following options to ensure your program purpose statement meets requirements while still adequately describing your individual program:

1. To provide more details of your specific program and practice setting, create an additional section in your program brochure, online information, syllabus and/or training plan that describes the setting and training opportunities. The ASHP online residency directory should also be used to describe your practice setting and experiences.
2. Review all program materials, including online resources and recruitment documents, to ensure all documents reflect the new statement.

Standard 3.3. Resident Learning

3.3.a Program Structure

The PGY1 accreditation standard describes a set of required competency areas, goals and objectives that must be used when designing learning experiences (LE) within a residency program.[5]

1. Patient care
2. Advancing practice and improving patient care
3. Leadership and management
4. Teaching, education, and dissemination of knowledge

Competency area 1 (Patient Care, which correlates to Standard 3.3.a (3), 3.3.a (4), 3.3.a (5)) delineates that programs are required to design patient care experiences within diverse patient populations, varied in the type of disease-states managed, and varied in the range of patient problems. Also, no more than one-third of the program may consist of a specific patient disease-state and population. Surveyed programs may have very-high level clinical services that integrate pharmacists but struggle with diversity (i.e., ethnicity, gender, age, disease) within the type of patient population being treated.

Tips:
Consider the following options to help build patient diversity into the program:

1. Create partnerships with community clinics or local providers to initiate an off-site service; consider services that are quick to start such as medication management, disease-state education, and transitions of care.
2. Propose a resident exchange with another local residency program for a rotation.
3. Consider collaborations with physicians in other areas of the institution for a rotation precepted by the physician.
    a. If considering this option, it is important to note that a majority of rotations/LE should be under direct preceptorship by a qualified pharmacist preceptor.
    b. Physician-precepted LE should occur later in the residency year when the resident has had sufficient exposure to pharmacist-precepted LE, and the RPD/preceptors agree that the resident is ready for independent practice.
        i. The RPD should work closely with the non-pharmacist preceptor to select educational goals and objectives (See Standard 4.10a/b)
4. If the program is struggling to build a diversity of disease-states and patient populations to be managed (> one-third of the program consists of the same patient population and/or disease state), it may be prudent to re-evaluate the overall designation of the program, and consider if the program is a better fit as a PGY1 community practice residency or PGY2 residency.

Another standard programs may struggle to meet is Standard 3.3.a (6) "residents must spend two-thirds or more of the program in direct patient care activities." Some programs may have residents spending excessive time in a dispensary role, performing medication reconciliation, or other non-direct patient care activities such as providing drug information. It is important to structure the 12-month schedule to include a majority of experiences in direct patient care (activities where the pharmacist is interacting at a high level of practice directly with the patient such as in-person or phone-based medication management, participating on hospital rounds, smoking cessation clinics, etc.).

Tips:
Consider the following options to ensure at least two-thirds of the residency program is in direct patient care activities:

1. Identify current non-direct patient care activities and see if direct patient care activities can be integrated into the activity
    a. Example: If the resident is performing medication reconciliation through electronic medical records without interacting with patients, require the resident to visit patients in-person (on rounds, in a group home, home visits, etc.) or do phone-based interviews with the patient.

2. Consider a partnership between a hospital and community site to establish a transitions of care program.
3. For inpatient settings, consider placing the resident with the on-call medical team once weekly to perform medication intake and management.
4. Consider building patient education activities into the program
    a. Example: Insulin injection classes, "Learn about Your Medication" classes, smoking cessation
        i. For example, if initiating an insulin injection class, perhaps having the class occur once weekly at the institution and once a month on a weekend will fill a need for patients and provide diversity to the program.
5. Critically evaluate each LE designed in the program and assess if the time assigned to that particular LE is appropriate to meet the goals and objectives.

Frequently, programs allot excessive time dedicated to one LE when in reality less time may be required in mastering these objectives. This will allow time to be reallocated to LE that are focused on direct patient care.

3.3.c. Learning Experiences

Most Commonly Cited Standards per Spring 2016 *Communique'*:

3.3c(1)(a) Learning experiences include a general description, including the practice area and the role of pharmacists in the practice area

3.3c(1)(d) For each objective, the learning experience contains a list of learning activities that will facilitate its achievement.

Many programs face challenges in properly developing their LE. Challenges include the following:

a. Providing an adequate description of the LE

Some programs do not have all LE developed and documented for each rotation. Other programs do not have one source such as a syllabus or training manual that is easily identified as containing all LE. It is important to note, programs are not required to use PharmAcademic™ or upload the LE descriptions to PharmAcademic™. However, there should be a place where residents can view their entire program and what is a required LE versus an elective LE.

Programs may also have inadequate descriptions of the LE, missing key components such as the role of the pharmacist, expectations of the resident, the length of the LE, objectives to be measured, and learning activities the resident will participate in.

Tips:
Consider the following options to help ensure your LE description is appropriate:

1. Visit the following link for an example LE [https://www.ashp.org/Professional-Development/Residency-Information/Residency-Program-Directors/Residency-Accreditation/Residency-Program-Design-and-Conduct]
2. Tips for providing an adequate description of the LE:
    a. Creating a syllabus or residency manual which contains all of the program's LE is important to guide the program and orient residents to the program.
    b. The Residency Program Director (RPD) should consider creating a template for all LE, so preceptors can ensure their LE is meeting all of the requirements.
    c. Consider the following components for all LE descriptions (**bolded** are the critical factors):
        i. Preceptor and site information

Table 1. Example of Learning Activities

Competency Area R1: Patient Care		
Goal	**Objectives**	**Learning Activities**
Goal R1.1: In collaboration with the health care team, provide safe and effective patient care to a diverse range of patients, including those with multiple co-morbidities, high-risk medication regimens, and multiple medications following a consistent patient care process.	Objective 1.1.1 (Applying) Interact effectively with health care teams to manage patients' medication therapy.	**Activities (good example):** • Attend multidisciplinary rounds daily and provide recommendations to improve medication therapy • Answer drug information questions for healthcare team **Activities (bad example, too vague):** • PKS and NSS consults
Competency Area R2: Advancing Practice and Improving Patient Care		
Goal	**Objectives**	**Learning Activities**
Goal R2.1: Demonstrate ability to manage formulary and medication-use processes, as applicable to the organization.	Objective 2.1.4: (Applying) Participate in medication event reporting and monitoring.	• Explain factors to consider when trying to determine the likelihood that a reaction is occurring because of a medication (learning activity is not written at the appropriate activity level for the objective [i.e., applying]). • Assess criteria for the severity of an adverse drug reaction. • Identify, investigate, and report adverse event on the adverse drug event reporting system.

ii. Description of the rotation/learning experiences including practice area [3.3.c(1)(a)]

iii. Responsibilities of the resident and the role of the pharmacist [3.3.c(1)(a)(b)]

iv. Description of how the resident will interact with other professionals at the clinic

v. **Table of goals, objectives and learning activities [3.3.c(1)(c) and 3.3.c(1)(d)] (See Table 1 for example)**

vi. Description of evaluations that must be completed by preceptors and residents [3.3.c(1)(e)]

Consider an evaluation schedule (See Table 2 for example)

vii. Expectations for the residents' progression [3.3.c(1)(b)] (see link above on LE example)

viii. Optional: Include a list of required or recommended readings and materials/tools resident is expected to have for the rotation (i.e., clinical guidelines, stethoscope, calculator)

b. Non-rotation Experiences

Many programs have non-rotation experiences such as research, teaching, staffing, leadership, etc. These experiences should be captured through objectives and evaluated.

Tips:

1. Create a separate LE for each experience and assign objectives appropriately. Each LE can be longitudinal for the duration of time required to complete the experience.
2. If creating a separate LE, consider lumping various experiences together. For example, if teaching is an LE, it can encompass CE's, in-services, patient education, and precepting under one LE.
3. Some programs tie external rotation experiences to a rotation and assign objectives within the rotation.

c. Assigning objectives appropriately for each LE, including mapping teaching vs. evaluating

Commonly noted during site visits is over-assigning an objective to be evaluated. When one objective is to be evaluated three or more times it may become redundant to the resident and burdensome for preceptors. Also, some programs make the mistake of assigning mandatory objectives to only the elective LE – this can lead to some objectives never being evaluated due to an LE that is not required.

Tips:

1. Collectively meet with all of the preceptors to discuss which objectives best fit with each LE. Generally, it is adequate to evaluate an objective one to two times for the entire program.

a. Print the taught and evaluated (TE) objective table (can download from PharmAcademic™) and use this during the meeting to visually see all of the LE.

b. Ensure that each objective is selected at least once for the mandatory LE. Some programs place an evaluation of an objective only during an elective LE. This is not appropriate and becomes an issue as the objective may never be evaluated if that particular rotation/LE is not selected by the resident.

c. Do not upload the LE to PharmAcademic™ until the entire mapping of the LE is completed. Additionally, ensure that a list of learning activities is completed for each objective before uploading, including "taught only" objectives.

Table 2. Example of Evaluation Plan for a Learning Experience

Evaluations to be completed	Schedule*	Expectations of Resident/Preceptor
Learning Experience Evaluation Summative	To be completed at the end of the 8-week rotation	Resident is expected to: • Complete ALL evaluations by the deadline (within seven days of the end of the rotation or learning experience). • Complete all evaluations in an objective manner. • Comment on areas that they see need for improvement. • Meet with preceptor for a face-to-face discussion about the evaluations.
Evaluation of Resident by Preceptor		Preceptor is expected to: • Complete ALL evaluations by the deadline (within 7 days of the end of the rotation or learning experience). • Make objective comments on areas the resident has improved and areas the resident can improve upon in relation to the educational objectives assigned to the LE. When recommending areas of improvement, please specify ways the resident can achieve the goal. • Meet with the resident for face-to-face evaluations.

* Outlook calendar reminders will be sent one week prior to due date of evaluation; email reminders will be sent two weeks prior to due date. [Resident and preceptor MUST meet in person to discuss evaluations]

Final Comment Box in PharmAcademic™ is encouraged to include:
- 3 Behaviors that contributed to resident's effectiveness and you would recommend continuing
- 1 area of opportunity for improvement
- Additional comments

d. Creating a list of learning activities for each objective

Writing appropriate learning activities for each objective is a challenge for programs across the board. Many programs copy and paste the criteria which are listed underneath the goals and objectives in the standard guidance document. These criteria are not learning activities and should not be employed as such. The criteria are useful to gauge whether or not the resident has mastered the activity and the extent of the mastery. Another common error is not assigning learning activities for "taught only" objectives.

Tips:

1. Learning activities are items in which residents will participate in and the expectations associated with the selected learning objective. The activity should conform to the context of the LE.
2. Utilize the Blooms Taxonomy verbs listed with each objective and ensure the list of learning activities match the taxonomy level.[6]
3. Enlist preceptors to create their own learning activities. Preceptors should reflect on the list of duties the resident will be performing and link the duties to the objectives selected for their LE.
4. Each objective must have one or more activities linked to it, but one activity may not be linked to more than one objective.
   a. If an activity can fit more than one objective, it is most likely not specific enough.
5. Any objective that is selected for an LE, even if it is selected as "taught only" must have learning activities assigned to it.
6. See Table 1 for an example of learning activities linked to objectives.

e. Describing the evaluation process for the LE

Missing from many LE descriptions is a statement or guidance piece on how and when the resident will be evaluated, and if there are any additional evaluations of the resident.

Tips:

1. It is helpful to orient both the preceptor and the resident by providing a description of how and when the evaluations of the resident will occur for the LE
2. If a preceptor wants to include additional evaluation documents (i.e., a presentation evaluation or teaching evaluation), this should be included in the evaluation description and an example of the evaluation document should be provided to the resident. (See Table 2 for example).

Standard 3.4.c. Performance Evaluation of the Resident, Preceptor and Sites

Most Commonly Cited Standards per Spring 2016 *Communique':*

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

Many programs have difficulty with multiple aspects of the evaluation process. ASHP has numerous resources available regarding the evaluation process. We will cover the updated standard requirements for frequency of evaluations since one of the most commonly cited standards is the timeliness of the evaluations.

The requirement for evaluations in the new standard is as follows:

1. Summative evaluations completed by the preceptor of the resident's performance must be completed at the end of each LE. If the LE is longer than 12 weeks, then the evaluation must be performed quarterly.
   a. If multiple preceptors are assigned to an LE, each preceptor may provide input into the resident's evaluation. All preceptors do not have to be assigned to an LE in PharmAcademic™.
2. Preceptor and LE evaluations completed by the resident should occur at the end of the LE and do not need to be performed quarterly for longitudinal LE (longer than 12 weeks).
   a. If a preceptor is assigned to more than one LE, a program may schedule only one evaluation for the preceptor; they do not need to be evaluated for each LE.
   b. It is optional to schedule mid-point or more frequent evaluations of a preceptor and an LE; discretion should be made based on resident success during the LE.
3. All evaluations must occur in both a written and verbal format within seven days of the end of an LE (if <12 weeks), or within seven days of the end of the quarter (if longitudinal).

Tips:

1. Pre-schedule all evaluations for the year in a shared calendar so the preceptor, resident and RPD allot dedicated time towards completing the evaluation in a timely manner.
   a. Programs that have been successful with timeliness often require preceptors to start documentation at the beginning of the last week of the LE so that all discussions about the evaluation can occur while the resident is still in the LE and become finalized on the last day of the LE.
   b. If preceptors are having difficulty accessing PharmAcademic™ due to

institution firewalls, print the evaluation and have preceptors do it on paper, then the RPD or Preceptor can transfer the evaluation electronically at a more convenient time (within seven days of the end of the LE).

2. Consider printing a report from PharmAcademic™ or self-generating a report of program objectives achieved by the resident quarterly which can also be incorporated into the Resident Development Plan. This report will be helpful to the RPD in managing resident progress through the program.
    a. Share the report with preceptors so they can focus on areas the resident has not achieved yet. Updates to the Resident Development Plan can be shared automatically with all preceptors through PharmAcademic™.
    b. It is important to determine who will have the ability to mark an objective "Achieved for the Residency (ACHR)". Many programs don't realize that this is a separate designation.
        i. ACH is achieved for an objective within a learning experience, and can be evaluated again during another LE.
        ii. ACHR is achieved for the residency, which can allow other evaluators in future LE or future time points to skip evaluating that objective.

Standard 3.4.d. Resident Development Plan

Most Commonly Cited Standards per Spring 2016 *Communique'*:

3.4d(2) On a quarterly basis, the RPD or designee assesses residents' progress and determines if the development plan needs to be adjusted.

Standard 3.4.d mandates that each resident must have a Resident Development Plan (formerly known as the customized plan) that is documented, shared with all preceptors, and updated quarterly. Some programs are too lengthy in their plans and lose track of goals they have set while other programs do not consistently complete, on a quarterly basis, evaluating the residents' progress and identifying new or revised goals for the next quarter. Based on the guidance document, an initial assessment of the incoming resident's strengths and areas for improvement is required, providing the basis for the resident's initial development plan. The resident's development plan should include assessment of and changes to the initial plan at each quarter and should include tracking of resident's progress toward achievement of the program's educational goals and objectives.

Tips:

1. An initial assessment is required; most programs choose to use the ASHP Entering Interest form. Of note, the Entering Interest form is not a substitute for an individualized resident development plan. If a program chooses to use their own Entering Interest form, it must assess the knowledge and skills related to the educational goals and objectives of the program. The initial assessment must be shared with all preceptors who will train the resident.
    a. If possible, a meeting for all program preceptors in May or June before the start of the residency year provides an opportunity to discuss any changes to the program, receive feedback about the previous residency year, and present the Entering Interest form of the incoming resident. This will allow for a real-time discussion and brainstorming session of ways the program should be modified

to meet the needs of the resident (which will become a resident development plan).

b. A discussion during orientation or within the first month of the program must occur with the resident to discuss the entering interest form and planned program changes/modifications.

c. The entering objective-based self-evaluation is required for all residents and can be scheduled through PharmAcademic™ prior to the start of the residency program.

2. Using a Google Docs™ or Microsoft Excel™ file may assist in keeping track of previous plans and modifying new plans.

   a. If a program is using PharmAcademic™, it is important to upload the forms to PharmAcademic™.

3. Setting up calendar reminders to conduct the quarterly update to the development plan or using PharmAcademic™ as the forum for the plan will help ensure the plan is reviewed and updated quarterly.

4. In general, the plan should focus on the following initially and quarterly (see Table 3 for an example of a resident development plan):

   a. Assessment of strengths and areas for improvement

   b. Assessment of resident's interest areas and desires for more or less experience in certain areas of the program

   c. Assessment of current progress of achieving goals and objectives, this should also include progress towards achievement of other residency completion requirements that have been designated by the program (e.g. submission of a manuscript, MUE, etc.)

   d. Adjustment of resident's plan based on the new assessments of resident's interests, abilities, and any areas that have been identified as low or no progress towards achievement of any of the residency's completion requirements.

   e. If no adjustment is necessary, documenting the reasons for no adjustments.

   f. Although optional, it may be helpful to assess career goals.

5. Including the resident's goals that have been ACHR (achieved for residency) and mapping out which ones have not yet been met, will also help in the formation of the residency program plan for the upcoming quarter and meet Standard 4.4b which states the RPD is responsible for oversight of the resident's progression within the program.

Preceptor Development

Most Commonly Cited Standards per Spring 2016 *Communique'*:

4.4e The RPD serves as the organizationally authorized leader of the residency program and has responsibility for creating and implementing a preceptor development plan for the residency program.

Many programs lack a documented plan and ability to track preceptor development. Each program is required to have a plan that defines how the RPD

Table 3. Example of Resident Development Plan

	Intake	Quarter 1	Quarter 2	Quarter 3
Date				
What are you most interested in learning during this residency?				
What skills do you currently have that you feel confident in?				
What skills are you hoping to develop?				
What do you see as your career path after the residency?				
(Only applicable for Quarters 1-3) [Resident] What changes would you like to see in your current program to help you succeed?				
(Only applicable for Quarters 1-3) [Resident] Have the current program plan and previous Quarter changes met your needs and enhanced your skills? If so, please state how; If not, please state why and what changes are needed.				
[Preceptor] What areas of need and/or objectives does the resident need more experience in to achieve success?				
[Preceptor] Have the previous quarter program plans been successful in aiding the resident in meeting their goals and achieving the program objectives?				
[Preceptor] general comments				
Objectives that are not achieved				
Program Plan for next quarter				

will assess preceptor skills and provide preceptor development. It is important to note that preceptor development does not translate to attending CE programs or other professional development activities, rather it is a plan that delineates how a program plans on helping preceptors improve their teaching, feedback skills, and developing their LE, etc. Most importantly, preceptors are asked to complete a self-assessment of their performance as a preceptor and identify what they believe their own personal development needs are in relation to residency training and responsibilities.

Tips:

1. Create a yearly self-assessment for preceptors to complete. Consider adding in a reflection on their comments/scores received from resident evaluations.
    a. It is important for preceptors to reflect on where they need to improve their precepting skills. It may be basic, such as reviewing the four preceptor roles (Direct Instruction, Modeling, Coaching, and Facilitating) or more advanced such as dealing with difficult personalities. Each preceptor should be encouraged to seek development yearly that helps them grow in their role as a preceptor.
2. Require a yearly update of the Academic and Professional Forms for each preceptor.
3. Create an excel file or shared doc that preceptors can fill out yearly to document their development. See Figure 1.
4. Resources for preceptor development that are available:
    a. ASHP has resources available on preceptor roles: [https://www.ashp.org/Pharmacy-Practice/Pharmacy-Topics/Preceptor-Skills]
    b. Holding an in-house RPD led preceptor development session
        i. The RPD can attend preceptor development training, then train their program preceptors
    c. Using Pharmacist's Letter® preceptor development continuing education
    d. Partnering with local schools of pharmacy for preceptor development workshops
    e. Purchasing webinars from national meetings for preceptor development
    f. Reading books related to the area of need
5. It is important to have a documented development plan that preceptors can access to see what the program requires of them.
    a. Some programs are very specific, requiring a certain number of CE hours or development programs to be completed.
    b. Some programs require at least one year to be dedicated to a specific development topic.
6. Consider adding regular topic discussions during the RAC (Residency Advisory Committee) meeting to have a brief tutorial/info sharing about best practices in the identified area.
    It is important to also keep minutes of these meetings to document the preceptor development process.

Miscellaneous Program Requirements

A. Duty Hours and Moonlighting

Most Commonly Cited Standards per Spring 2016 *Communique'*:

2.2 The program complies with the ASHP Duty-Hour Requirements for Pharmacy Residencies.

Most programs follow ASHP duty hour requirements but are cited for not having the duty hour policy clearly written in the residency manual. In addition, many programs are missing language regarding outside employment and staffing. Ultimately, the RPD may prohibit any staffing and moonlighting if the resident's performance is compromised.

Tips:

1. Do not simply refer to the ASHP duty hour link as the entire duty hour policy.
2. Duty hour policies must include how hours will be certified/monitored.
3. Duty hour policy must have language regarding outside employment and staffing.
    a. Programs that allow moonlighting must have a process to monitor the hours, including at minimum (language below is directly from Standard 2.2 of the 2014 PGY1

Figure 1. Example of a Preceptor Development Tracking Tool

Preceptor	Areas of preceptorship that may need improvement; please reflect on previous evaluations	Attended in-house training program [May 2016]	Attended ASHP RPDC (Residency Development Design and Conduct Conference) [Date attended]	Please list all other residency preceptor training workshops and dates attended (Example: Pharmacist Letter; ASHP Workshops, etc.)	Comments/ future development plans (Include workshops, CE training, webinars, personal assessment based on resident's comments/evaluations)

Accreditation Standards requires compliance with the ASHP's "Duty-Hour Requirements for Pharmacy Residencies")[7]:

i. *The type and number of outside employment hours allowed by the program.*
ii. *A reporting mechanism for residents to inform the residency program directors of their outside employment hours.*
iii. *A mechanism for evaluating residents' overall performance or residents' judgment while on scheduled duty periods and affect their ability to achieve the educational goals and objectives of their residency program and provide safe patient care.*
iv. *A plan for what to do if residents' participation in outside employment affects their judgment while on scheduled duty hours. including clearly stated language that the RPD has the authority to prohibit the resident from engaging in outside employment if that employment is seen to be having a negative impact on the resident's ability to fulfill the residency program requirements.*
v. *Mandatory time free of duty: residents must have a minimum of one day in seven days free of duty (when averaged over four weeks). At-home call cannot be assigned on these free days.*
vi. *Residents should have ten hours free of duty between scheduled duty, and must have at a minimum of eight hours between scheduled duty periods." (per ASHP duty hour requirements)*

B. Offer Letter/Licensure requirements

Most Commonly Cited Standards per Spring 2016 *Communique'*:

1.5 Consequences of residents' failure to obtain appropriate licensure either prior to or within 90 days of the start date of the residency are addressed in written policy of the residency program.

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

2.4b Residents' acceptance of these terms and conditions, requirements for successful completion, and expectations of the residency program is documented prior to the beginning of the residency.

Commonly, programs do not have a formal offer letter in place before the start of the program. In addition, programs do not have clear language defining licensure requirements, graduation requirements, and consequences for not meeting the requirements. It is mandatory for programs to document the requirements for successful program completion and expectations of the resident.

Tips:

1. Offer letters, policy and procedure manuals, and residency training manuals should all utilize the same language and specifically refer to licensure requirements, graduation requirements, and leave policies (See Table 4 for offer letter example).
    a. All requirements for program completion must be provided to applicants invited to interview, including policies for professional, family, and sick leaves and the consequences of any such leave on residents' ability to complete the residency program and for dismissal from the residency program.
    i. The most common reason for the citation of Standard 1.6 is due to the program's extended leave policy, or requirements for the successful completion of the program have not been included in the materials given to the candidates invited to interview.
2. Standard 1.5 was changed to a critical factor requiring residents to be licensed prior to or within 90 days of the start of the residency. This allows residents to spend a majority of their program functioning at a level necessary to achieve required competency areas (two-thirds of the residency program).
    a. Language for licensure requirements must be consistent in all documents relating to the program
    b. Specific language discussing the consequences of failing to obtain licensure within the specified time should be developed and provided.
    c. If allowing for an extension beyond the 90-day period, a policy should be documented on how the program will ensure the resident completed two-thirds of their 12-month program as a licensed practitioner. Also, there should be language on the maximum amount of time a program will allow as an extension and if the resident will receive compensation for the period of extension.

Overall, programs are encouraged to assess that they are complying with all critical factors within the standards to ensure their programs meet with the highest success during site visits. As the standards continue to be refined and evolved over time, it is prudent for program directors to be familiar with all updates and share them with program preceptors.

Table 4. Offer Letter Example

Dear XX,

Thank you for your interest in the PGY1 Pharmacy Residency Program offered by XX. On behalf of XX, I would like to extend an offer to you for our PGY1 Pharmacy Residency Program. We believe this residency will provide you the opportunity to accelerate your growth to a high level of professional competence in direct patient care and to further the development of leadership, teaching, and research skills that can be applied in your future professional endeavors.

As part of the program, you will need to complete an appropriate orientation at XX through our Human Resources Department. The salary for the position is $XX per year, and benefits include 15 days paid time off, and medical and dental insurance. A $XX travel stipend will also be made available. Should a situation arise for which you need extended family or sick leave beyond the 15 days paid time off provided as benefits by XX, your residency duration would need to be extended to complete the program (please refer to the policy and procedure document for program extension policies).

This residency is a 12-month commitment, commencing on July 1, 2016, and ending June 30, 2016, during which time specific program requirements must be completed as outlined in this offer letter, the program syllabus and the RAC (Residency Advisory Council) policy and procedure document.

As part of this program, you will be required to:

1. Abide by all XX institution employee policies.
2. Abide by all policies defined in the RAC policy and procedure document. I acknowledge receipt and acceptance of this document: _____ (initials)
3. Abide by all policies defined in the program syllabus document. I acknowledge receipt and acceptance of this document: _____ (initials)
4. Complete a yearlong research project:
    a. Finalize a research project topic by September 30, 2016;
    b. Present your findings at the Western States Conference; and
    c. Complete a manuscript of your research project suitable for publication by the end of your residency.
5. Achieve goals and objectives as outlined in the program syllabus:
    a. Competency Areas R1, R2, R3, and R4 must be marked at the achieved level by the end of the residency by the residency program director (resident must achieve 80% of objectives at a minimum of satisfactory progress and the remaining 20% must be marked at either achieved or satisfactory progress to be considered achieved for the outcome/goal).
6. Participate in one medication use evaluation (MUE), including development, data collection and analysis, intervention/action planning and follow-up.
7. Create a drug monograph suitable for presentation purposes.
8. Attain pharmacy licensure as soon as possible, but at the latest within 90 days of the start of the residency program. Failure to attain licensure by November 1st may result in a non-paid leave-of-absence (LOA) as approved by both the program director and the pharmacy director. If a LOA is approved, a program extension may be granted for a max of 3 months (90 days) to allow for a make-up of time missed during the LOA. If a LOA is not granted, the resident will be dismissed from the program effective immediately. The resident must practice for a minimum of 8 months as a licensed pharmacist in direct patient care services.
9. Complete the teaching certificate program:
    a. Attend boot camp and at least 80% of teaching certificate didactic/workshop sessions;
    b. Present one journal club to the post-doc journal club meetings and participate in at least 80% of the other journal club meetings unless excused by residency program director;
    c. Provide a CE, FOD session, didactic lecture or equivalent activity requiring the development of learning objectives and assessment questions.
    d. Develop and maintain a teaching portfolio
        i. Must include the following, but not limited to:
            1. CV
            2. Philosophy of teaching
            3. Handouts and materials taught
            4. Evaluations
            5. Self-reflections (if completed)
10. Participate in all PharmAcademic™ evaluations by the specified dates in the PharmAcademic™ system.
11. Attend all orientation programs offered XX institution. (As deemed relevant by your residency program director)

If you have any questions or concerns, please do not hesitate to contact me. As an acknowledgment and acceptance of the terms and conditions of this residency program, please sign and date this letter below and return it within five days of receipt.

Sincerely,

XX

Disclaimer

The advice provided in this article is not intended to be a comprehensive review of all required documents and standards required for a successful accreditation visit. The advice in this article is also not a guarantee of any certain accreditation outcome. It is always prudent to review all accreditation requirements outlined by ASHP and discuss any concerns with your assigned Lead Surveyor. Reaching out to local residency programs that have similar characteristics may also be helpful to share ideas and resources. ○

Addenda

After this manuscript was accepted for publication, three noteworthy upates occurred:

1. The Fall 2016 *Communique*' was published and can be found here: https://www.ashp.org/professional-development/residency-information/residency-program-directors/communique-newsletter
2. A new mandatory requirement for programs has been released: All programs in the accreditation process, including candidate and accredited programs, MUST utilize PharmAcademic© to close out their residents at the end of the 2016-17 residency year.
3. ASHP recently released a new website. Visit ashp.org > residency information > residency directors, or use the search function for more information.

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