PGY1 Community-focused Pharmacist Residency Standard

Purpose of the Standard: Community-focused residency education and training aim to create pharmacy leaders who are capable of improving the health of patients within their community. The primary purpose of this Standard is to foster the development of community-focused pharmacist practitioners who are practice leaders and who have the skillset necessary to provide quality patient care wherever community health and medication needs arise.

Application of the Standard: It is recognized that in the application of this optimal Standard, training locations may vary. Additionally, because of the diversity of patient populations, service offerings, and business models, it is recognized that individual practice locations\(^1\) may be unable to provide all of the Standard’s requirements for diversity, variety, and complexity. However, it is intended that the combination of all practice locations used for the training of the individual resident fully meet the requirements as set forth by the Standard, and each resident has a designated home-base\(^2\) practice location.

A variety of community-based programs with practice locations that meet the intent of this Standard may use this Standard. These programs include, but are not limited to community pharmacies, ambulatory care clinics, physician offices, free clinics, federally-qualified health centers, employer-based clinics, assisted living facilities, hospice, home care, and adult/pediatric hospitals with outpatient pharmacies/clinics.

About this Standard: This optimal Standard was developed by the American Pharmacists Association (APhA) in cooperation with the American Society of Health-System Pharmacists (ASHP). This Standard is aligned with the future vision for community residency training as developed by the APhA Community Pharmacy Residency Planning Committee, 2015. All programs applying this Standard must be in compliance with APhA and ASHP rules and regulations.

\(^1\) PGY1 Community Practice Location Definition: Place(s) where preceptors are training residents. A practice location may consist of one or more places where the resident can be trained within a single organization (i.e. a pharmacy chain, a college of pharmacy with clinic pharmacies, a health-system with outpatient/clinic pharmacies).

\(^2\) Home-base Practice Site Definition: Practice location designated as the resident’s primary site and used as the name for the residency.
Standard 1: Requirements for Resident Selection and Resident Completion of the Program

1.1 The residency program director (RPD) or RPD designee, in coordination with members of the Residency Advisory Committee (RAC), evaluate the qualifications of applicants to pharmacy residencies through a documented, formal procedure based on predetermined criteria.

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

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

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

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

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

Standard 2: Responsibilities of the Program to the Resident

2.1 Programs are a minimum of twelve months and a full-time practice commitment or equivalent.

2.1.a Non-traditional residency programs describe the program’s design and length used to meet the required educational competency areas, goals, and objectives.

2.2 Programs comply with the ASHP duty hour standards. (http://www.ashp.org/DocLibrary/Accreditation/Regulations-Standards/Duty-Hours.aspx)

2.3 All programs in the ASHP accreditation process adhere to the Rules for the ASHP Pharmacy Resident Matching Program, unless exempted by the ASHP Commission on Credentialing.

2.4 The RPD provides residents who are accepted into the program with a letter outlining their acceptance to the program.

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

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

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

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

2.8 The RPD only issues a certificate to residents who complete the program’s requirements in accordance with the provisions of the ASHP Regulations on Accreditation of Pharmacy Residencies.
   2.8.a Certificate is signed by the RPD and the chief executive officer of the organization or an appropriate executive with ultimate authority over the residency.
   2.8.b Reference is made on the certificate of the residency that the program is accredited by ASHP and its partner, APhA.

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

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

3.1 Residency Purpose and Description

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

PGY1 Community Pharmacy Residency Program Purpose: PGY1 Community-focused residency education and training builds upon competencies attained in doctor of pharmacy education to prepare community-focused pharmacist practitioners with advanced patient care, leadership and education skills for the delivery of diverse patient-centered care and services. Graduates will be prepared to be community-based primary care providers and be enabled, if desired, to pursue board certification and/or postgraduate year two (PGY2) pharmacy residency training.

3.1.a Programs may develop a brief description of their program that aligns with the purpose statement of a PGY1 community-focused residency and elaborates on the unique aspects of their program.
3.2 Competency Areas, Educational Goals and Objectives
   3.2.a The program’s educational goals and objectives support achievement of the residency’s purpose.

   3.2.b The following (are proposed draft competencies currently in development as of June 2015) competency areas and all associated educational goals and objectives are required by the Standard and are included in the program’s design:
      1. patient care including patient-centered dispensing
      2. advancement of community-focused practice
      3. leadership and management
      4. teaching, education, and dissemination of knowledge

   3.2.c The RPD, in coordination with the RAC, may select or create additional competency areas that become required for all residents in the program.

   3.2.d The RPD may select or create elective competency areas to customize the training for a specific resident.

3.3 Resident Learning
   3.3.a Program Structure
      3.3.a.1 The structure of the program is established, described, and formally documented.
         3.3.a.1.1 The description includes a list of all required and elective learning experiences.
         3.3.a.1.2 The description includes the type (e.g. longitudinal, rotational, extended, concentrated) of each learning experience.
         3.3.a.1.3 The description includes the duration for each learning experience.

      3.3.a.2 The program’s structure facilitates achievement of the program’s educational goals and objectives.

      3.3.a.3 The structure permits residents to gain experience and sufficient practice with diverse patient populations, a variety of disease states and conditions, and a range of patients’ medication and health-related needs.

   3.3.b Learning Experiences Requirements
      3.3.b.1 Learning experience descriptions are documented and include:
         3.3.b.1.1 a general description, including the practice area and the roles of pharmacists in the practice area;
         3.3.b.1.2 expectations of residents;
         3.3.b.1.3 educational goals and objectives assigned to the learning experience;
         3.3.b.1.4 for each objective, a list of learning activities that will facilitate its achievement; and
         3.3.b.1.5 a description of evaluations that are to be completed by preceptors and residents.
3.3.b.2 Program structure includes a residency program orientation learning experience where the RPD, RPD designee, or residency program coordinator (RPC) orients residents to the residency program.

3.3.b.3 For all other learning experiences, preceptors orient residents to their learning experience including review of the learning experience description.

3.3.b.4 The learning experience design:
   3.3.b.4.1 requires preceptors to use the four preceptor roles.
   3.3.b.4.2 enables residents to progress over the course of the residency to become more efficient, effective, and able to work independently.

3.4 Assessment and Evaluation Requirements
3.4.a RPD and Preceptor Evaluation Requirements
3.4.a.1 Initial assessment
   3.4.a.1.1 At the beginning of the residency, the RPD, RPD designee or RPC, in conjunction with preceptors, assesses each resident’s entering knowledge and skills in relation to the educational goals and objectives.

3.4.a.2 Formative (on-going, regular) assessment
   3.4.a.2.1 Preceptors provide on-going frequent, immediate, specific, and constructive feedback to residents about how they are progressing and how they can improve.
   3.4.a.2.2 Preceptors make appropriate adjustments to residents’ learning activities in response to information obtained through day-to-day informal observations, interactions, and assessments.

3.4.a.3 Summative evaluation
   3.4.a.3.1 At the end of each learning experience, preceptors complete and document a criteria-based, summative evaluation of the resident’s progress toward achievement of educational goals and objectives assigned to the learning experience.
   3.4.a.3.1.1 If more than one preceptor is assigned to a learning experience, all preceptors provide input into the resident’s evaluation.
   3.4.a.3.1.2 For longitudinal learning experiences greater than 12 weeks in length, a documented summative evaluation is conducted at least twice; once at the midpoint and once at the end of the learning experience.

   3.4.a.3.2 The preceptor and resident discuss the summative evaluation and the extent of the resident’s progress toward achievement of assigned educational goals and objectives with reference to specific criteria.
3.4.a.3.3 Completed summative evaluations are signed by the preceptors and reviewed and co-signed by the RPD or RPD designee.
3.4.a.3.3.1 For preceptors-in-training, both the preceptor-in-training and the preceptor advisor/coach sign evaluations.

3.4.b Resident Evaluation Requirements
3.4.b.1 Self-Reflections (Beginning and end of residency)
3.4.b.1.1 Residents complete a written statement of self-reflection at the beginning of the residency to identify learning expectations and desired areas of professional growth.
3.4.b.1.2 Residents complete a written statement of self-reflection at the conclusion of residency to identify competencies achieved, competencies requiring additional attention, and a plan for future professional development.

3.4.b.2 Initial Assessment
3.4.b.2.1 Residents complete a self-assessment of their entering knowledge and skills related to the educational goals and objectives.

3.4.b.3 Formative Assessment
3.4.b.3.1 Residents practice criteria-based, formative self-evaluation for aspects of their routine performance.

3.4.b.4 Summative Evaluation
3.4.b.4.1 Residents complete and document a criteria-based, summative self-evaluation of their progress toward achievement of educational goals and objectives assigned to the learning experience.
3.4.b.4.2 The self-evaluations are to be completed on the same schedule as required of the preceptor for the learning experience.

3.4.b.5 Resident Evaluation of Preceptor
3.4.b.5.1 Residents complete at least one evaluation of each preceptor assigned to a learning experience.
3.4.b.5.1.1 For longitudinal learning experiences greater than 12 weeks in length, preceptor evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.
3.4.b.5.1.2 If one preceptor is assigned to more than one longitudinal learning experience, the resident may only complete one combined evaluation for the individual preceptor.
3.4.b.5.2 The preceptor and resident discuss the preceptor evaluation.
3.4.b.5.3 Completed preceptor evaluations are signed by the preceptors and reviewed and co-signed by the RPD or RPD designee.
3.4.b.6 Learning Experience Evaluations

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

3.4.b.6.1.1 For longitudinal learning experiences greater than 12 weeks in length, learning experience evaluations are conducted at least twice; one no later than the midpoint and one at the end of the learning experience.

3.4.b.6.2 The preceptor(s) and resident discuss the learning experience evaluation.

3.4.b.6.3 Completed learning experience evaluations are signed by the preceptor(s) and reviewed and co-signed by the RPD or RPD designee.

3.5 Residents’ Development Plans

3.5.a The RPD, RPD designee or RPC create, document, and maintain a development plan for each resident.

3.5.a.1 The RPD, RPD designee, or RPC creates an initial development plan.

3.5.a.1.1 The initial plan is based on the results of residents’ initial assessments.

3.5.a.1.2 The initial plan is completed by the end of the orientation period, but no later than 4 weeks into the residency.

3.5.a.1.3 Adjustments to the residents’ learning experiences, learning activities, evaluations, and other changes are documented in the initial plan.

3.5.a.2 On a quarterly basis, the RPD, RPD designee, or RPC assesses residents’ progress and adjusts the development plan.

3.5.a.3 The development plan and any adjustments are documented and shared with all of the resident’s preceptors.

3.6 Continuous Residency Program Improvement

3.6.a The RPD and the Residency Advisory Committee (RAC) with appropriate stakeholder representation, engage in an on-going process of assessment of the residency program including a formal annual program evaluation.

3.6.b The RPD, RPD designee, or RPC develops and implements program improvement activities to respond to the results of the assessment of the residency program.

3.6.c The residency program’s continuous quality improvement process evaluates whether residents fulfill the purpose of a PGY1 community pharmacy residency program through graduate tracking.

Standard 4: Requirements of the Residency Program Director and Preceptors

4.1 Program Leadership Requirements

4.1.a Each residency program has a designated sponsoring organization.

4.1.a.1 For residencies conducted by one organization, that organization is the designated sponsoring organization.
4.1.a.2 When a residency is conducted by more than one organization (two organizations in partnership, such as a college of pharmacy, company or health system), the partners will agree to and designate the sponsoring organization in a formal agreement.

4.1.a.2.1 The agreement includes definition of:
- 4.1.a.2.1.1 responsibilities of all partners;
- 4.1.a.2.1.2 responsibilities of the RPD; and
- 4.1.a.2.1.3 RPD’s accountability to the organizations.

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

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

4.1.b.2 The RPD may delegate, with oversight, to one or more individuals (e.g., residency program coordinator(s)) administrative duties/activities for the conduct of the residency program.

4.2 Residency Program Directors (RPD)

4.2.a Eligibility of the RPD

An RPD is a licensed pharmacist who:
- has completed an ASHP-accredited PGY1 residency and a minimum of three years of pharmacy practice experience in a community or ambulatory practice environment; or
- has completed ASHP-accredited PGY1 and PGY2 residencies with one or more years of pharmacy practice experience in a community or ambulatory practice environment; or
- has not completed an ASHP-accredited residency, but has five or more years of pharmacy practice experience in a community or ambulatory practice environment.

4.2.b Qualifications of the RPD

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

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

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

4.2.b.3 participation in workgroups or committees within the organization.

4.2.c Leadership Responsibilities of the RPD

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

4.2.c.1 organization and leadership of a RAC that provides guidance for residency program conduct and related issues;

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

4.2.c.3 appointment of preceptors for the program;
4.2.c.3.1 RPDs, in cooperation with site coordinators and partnering organization when applicable, identify preceptors for the program.
4.2.c.3.2 RPDs develop and apply criteria consistent with those required by the Standard to qualify preceptors for the program.
4.2.c.3.3 RPDs appoint preceptors once qualified.
4.2.c.3.4 RPDs create and implement an overall preceptor development program and oversee the creation of individual preceptor development plans.

4.2.c.4 Leadership of continuous residency program improvement in conjunction with the RAC; and
4.2.c.5 collaboration with all partners of the program.

4.3 Residency Program Coordinators (RPC)
An RPC may be appointed if determined to be appropriate for the structure and implementation of the residency program.

4.3.a Eligibility of the RPC
An RPC is a licensed pharmacist who:
- has completed an ASHP-accredited PGY1 residency and a minimum of two years of pharmacy practice experience in a community or ambulatory practice environment; or
- has completed ASHP-accredited PGY1 and PGY2 residencies with 1 year of pharmacy practice experience in a community or ambulatory practice environment; or
- has not completed an ASHP-accredited residency, but has three or more years of pharmacy practice experience in a community or ambulatory practice environment.

4.3.b Qualifications of the RPC
An RPC serves as a role model for pharmacy practice, as evidenced by:
4.3.b.1 leadership within the pharmacy department or within the organization, through documented record of improvements in and contributions to pharmacy practice;
4.3.b.2 residency preceptorship for a minimum of 2 years;
4.3.b.3 demonstration of ongoing professionalism and contribution to the profession; and
4.3.b.4 participation in workgroups or committees within the organization.

4.3.c Leadership Responsibilities of the RPC
An RPC serves at the direction of the RPD and may be responsible for:
4.3.c.1 assisting with residency orientation, as required.
4.3.c.2 assisting with the creation of residents’ development plans and adjustments, when necessary.
4.3.c.3 coordinating residents’ daily schedules between practice sites.
4.3.c.4 overseeing residents’ learning experiences.
4.3.c.5 coordinating residents’ evaluation processes.
4.3.c.6 providing program level training and communications.
4.3.c.7 organizing residency recruitment activities and interviews.
4.4 Pharmacist Preceptor

4.4.a Eligibility of Preceptors
A pharmacist preceptor is a licensed pharmacist who:

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

4.4.b Qualifications of Preceptors
Preceptors demonstrate the ability to precept residents’ learning experiences as evidenced by:

- 4.4.b.1 ability to precept residents by demonstrating the use of preceptor roles (i.e., instructing, modeling, coaching, facilitating) at the level required by residents;
- 4.4.b.2 ability to assess and provide appropriate feedback on the residents’ performance;
- 4.4.b.3 recognition in the area of pharmacy practice for which they serve as preceptors;
- 4.4.b.4 an established, active practice in the area for which they serve as preceptor;
- 4.4.b.5 maintenance of continuity of practice during the time of residents’ learning experiences; and
- 4.4.b.6 ongoing professionalism, including a personal commitment to advancing the profession.

4.4.c Preceptors’ Responsibilities
Preceptors serve as role models for learning experiences and they:

- 4.4.c.1 contribute to the success of residents and the program;
- 4.4.c.2 create, implement, and maintain learning experiences in accordance with Standard 3;
- 4.4.c.3 participate actively in the residency program’s continuous quality improvement processes;
- 4.4.c.4 demonstrate practice expertise and preceptor skills, and strive to continuously improve;
- 4.4.c.5 instruct the resident in learning experiences using established preceptor roles (i.e., instructing, modeling, coaching, and facilitating) at appropriate levels required by the individual resident.
- 4.4.c.6 adhere to residency program and department policies pertaining to residents and services; and
- 4.4.c.7 demonstrate commitment to advancing the residency program and pharmacy services.
4.4.d Preceptors-in-Training
  4.4.d.1 Pharmacists who do not fully meet the qualifications for residency preceptors in sections 4.4a, b, and c above) are designated as Preceptors-in-Training.
  4.4.d.1.1 Each is assigned an advisor or coach who is a qualified preceptor.
  4.4.d.1.2 Each has a documented preceptor development plan to achieve qualifications to become a residency preceptor within two years.

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

Standard 5: Requirements for the Organization(s) Conducting the Residency Program

5.1 Sponsoring Organization
  5.1.a All residency programs must have a sponsoring organization.
  5.1.b The sponsoring organization maintains authority and responsibility for the quality of the residency program.
  5.1.c The sponsoring organization ensures that the residency program meets accreditation requirements.
  5.1.d Sponsoring organizations and all partnering organizations have signed agreement(s) that clearly define the responsibilities for all aspects of the residency program.
    5.1.d.1 A method of evaluation is in place to ensure that the purpose of the residency and the terms of the agreement are being met.
    5.1.d.2 A mechanism is established and documented for achieving consensus among partners on the evaluation and ranking of applicants for the residency.
5.2 PGY1 Community-focused Multiple-Site Residency Program is defined to be a sponsoring organization in partnership with more than one organization with each partner organization providing a home base practice site for each resident matched to their site.

5.2.a For multiple-site programs the authorized RPD appoints, in cooperation with the practice, a site coordinator to manage and oversee the day-to-day operations of the residency program at each home-base practice location.

5.2.b RPD, RPC, site coordinators, and the partnering organization, when applicable, work together to appoint and develop pharmacy staff to become preceptors for the program.

5.2.c A mechanism is documented for achieving consensus between partners on the evaluation and ranking of applicants for the residency.

5.2.d Multiple-site residency programs are in compliance with the ASHP Accreditation Policy for Multiple-Site Residency Programs.

5.3 Practice Location(s)

5.3.a Practice locations(s) compare the quality, safety and financial viability of the patient care services provided at the location against national professional guidelines and Board of Pharmacy requirements to determine areas for improvement. Practice locations seek accepted outside appraisal of facilities and patient care practices when applicable. The external appraisal is conducted by a recognized organization appropriate to the practice.

5.3.b Practice locations have staff that are committed to seek excellence in patient care as evidenced by substantial compliance with professionally developed and nationally applied practice and organizational guidelines and standards, and are provided with sufficient resources to adequately conduct the program.

5.3.c Multiple Training Location Program

5.3.c.1 A program designs the structure of their program to use one or more additional practice locations for training an individual resident beyond the resident’s home-base practice location.

5.3.c.2 Additional practice locations meet the requirements set forth in pharmacy’s service requirements in Standard 6.

5.4 Designation of a Home-Base Practice Site

5.4.a Each resident will be assigned a home-base practice site.

5.4.b Home-base practice site meets the patient care service criteria under 6.5d and 6.5e of the Standard.

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

5.4.d Multiple practice locations within a defined geographical area may be used in addition to the home-base practice location to train residents. A College of Pharmacy (COP) is
considered a practice location only if the COP has practice locations serving as a home-base.

**Standard 6: Requirements for Practice Locations**

Appropriate resources are available and used for services provided within the individual practice locations. Appropriate resources may include, but are not limited to: the most current editions of *Medication Therapy Management in Pharmacy Practice*, APhA and NACDS Foundation’s *Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model*, APhA and ASHP’s *Improving Care Transitions: Optimizing Medication Reconciliation*, JCPP Pharmacists’ Patient Care Process, CPPA Standards, ISMP, PQA, the ASHP *Best Practices for Health-System Pharmacy*, and other relevant standards (e.g., NIOSH, OSHA, EPA), *The Patient Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*. The pharmacy services required for training the resident may be offered at one practice location or a combination of practice locations as described under 5.4 and meet the requirements of Standard 6.

6.1 Practice Management

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

6.1.b The scope and quality of the services provided to patients is based upon the mission of the practice and an assessment of pharmacist services needed to provide care to patients served.

6.1.c If applicable, the practice strategic planning committee includes pharmacist representatives in the planning of patient care services.

6.1.d The practice provides effective leadership and management for the achievement of the practice’s/pharmacy’s short and long term goals.

6.1.e The practice has documented policies and procedures to deliver evidence-based care in the practice.

6.1.f The practice has procedures to document, track, evaluate and report patient care outcomes data.

6.1.g If medications are used, prepared or distributed within the practice, pharmacists are responsible for the procurement, preparation, distribution, and control of all medications used.

6.1.h When applicable, pharmacist services extend to all areas of the practice internally, and externally to the pharmacy in which medications for patients are prescribed, dispensed, administered, and monitored.

6.1.i Within the practice, pharmacists are responsible for collaborating with other health professionals to ensure safe medication-use systems and optimal drug therapy, and are integral members of the patient’s health care team.

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

6.1.j.1 a mission statement;

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

6.1.j.3 descriptions of roles and responsibilities for all categories of pharmacy personnel, including residents;
6.1.j.4 procedures to ensure that medication-use systems (ordering, dispensing, administration, and monitoring) are safe and effective;
6.1.j.5 procedures to ensure that pharmacists’ patient care services are safe and effective; and
6.1.j.6 appropriate professional and support staff to deliver quality services.

6.2 Pharmacists providing patient care, dispensing services, or other professional services at the practice location will, as applicable
6.2.a manage selection, procurement, storage, and dispensing of medications used within the organization.
6.2.b prospectively review, evaluate and assess the appropriateness and safety of medication prescriptions/orders.
6.2.c develop and define protocols for the delivery of patient care services
6.2.d proactively provide education and counseling to patients regarding medications and related products.
6.2.e communicate with patients and families as appropriate to address and resolve potential barriers to safe and effective medication use (e.g., literacy, access, language needs).
6.2.f continually collaborate, document, and communicate with physicians, other pharmacists, patients and other health care professionals as an interprofessional team in the provision of safe, effective, and coordinated patient-centered care.
6.2.g consistently follow the JCPP Pharmacists’ Patient Care Process (collect, assess, plan, implement, and follow-up: monitor and evaluate) using principles of evidence-based practice.
6.2.h identify and take responsibility for resolution of drug therapy problems.
6.2.i perform physical assessments and conduct, order and interpret laboratory tests based on collaborative practice agreements or other treatment protocols consistent with the law, regulations, and practice policies and procedures.
6.2.j participate in initiating, modifying, and discontinuing drug therapy, and administering medications, based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures.
6.2.k administer medications based on collaborative practice agreements or other treatment protocols consistent with the laws, regulations, and practice policies and procedures.
6.2.l manage adverse drug event monitoring, resolution, reporting, and prevention programs.
6.2.m provide educational programs about medications, medication therapy, health and other related matters to patients, caregivers, and health-care providers.
6.2.n participate in projects and activities relating to improving population health.

6.3 Pharmacy management and staff provide safe and effective medication preparation and distribution services for all medications used or distributed within the practice site. This applies to the drug dispensing service and all services provided by the pharmacy.
6.3.a The pharmacy is in compliance with all applicable federal, state, and local laws, codes, statutes, and regulations governing pharmacy practice unique to the practice site.
6.3.b The pharmacy is in compliance with current national practice standards and guidelines.
6.4 The pharmacy practice location or a combination of multiple practice locations (i.e. a multiple training location program) provides the resident with the opportunity to practice in an environment that provides sufficient scope, breadth and depth of pharmacist patient care services, and sufficient time for longitudinal development of patient relationships and provision of patient care to meet the intent of the Standard.

6.4.a The practice locations provide a sufficient number of patients in longitudinal relationship to provide adequate scope, breadth, diversity, complexity of patient care.

6.4.b Pharmacists’ patient care services that must be provided include:
   6.4.b.1 Medication Management including the provision of comprehensive medication reviews and follow-up;
   6.4.b.2 Health and Wellness Services;
   6.4.b.3 Immunization Services;
   6.4.b.4 Disease state management services incorporating medication management; and
   6.4.b.5 Care transition services with incorporated medication reconciliation and medication management.

6.5 Practice locations that have pharmacists providing medication dispensing/ preparation/distribution:
   6.5.a Provide a safe and effective medication preparation and distribution service for all medications used or distributed within the practice.
   6.5.b Provide routine patient counseling and education services on medication initiation, with any change to medication therapy for high-risk medications and high-risk patients.
   6.5.c Provide evidence-based targeted interventions integrated into the patient-centered dispensing process.
   6.5.d Provide medication management services including comprehensive medication reviews and follow-up within the complete system of the practice location.
   6.5.e Provide additional patient care services (minimum of 2 of the following) within the practice location:
      6.5.e.1 Health and wellness services (e.g. blood pressure screenings, cholesterol screenings, osteoporosis screenings, smoking cessation programs, weight loss programs);
      6.5.e.2 Immunization services;
      6.5.e.3 Services to monitor and improve patients’ medication adherence
      6.5.e.4 Care transition services with incorporated medication reconciliation and medication management;
      6.5.e.5 Chronic disease education services; and/or
      6.5.e.6 Chronic disease management services.

6.6 Practice locations have personnel, facilities, and other resources required to provide the services pursuant to the learning experiences designated to the practice location and the needs of the patient population of the practice. Where applicable, the practice location(s):
   6.6.a are designed, constructed, organized, and equipped to promote safe and efficient work;
6.6.b are designed to accommodate confidential patient assessment, counseling, and provision of patient care;
6.6.c have professional, technical, and clerical staff sufficient and diverse enough to ensure that the department can provide the level of service required by all patients served;
6.6.d have a system fostering accountability and optimization of safe medication-use system technologies.
6.6.e have access to appropriate medical informatics, patient assessment tools, and technology necessary to provide the scope of services; and
6.6.f have systems to support the connectivity and interoperability of information systems.

6.7 Practice Location Continuous Quality Improvement
6.7.a Practice personnel engage in an on-going process to assess the quality of pharmacy services.
6.7.b Practice personnel develop and implement pharmacists’ patient care services improvement initiatives in response to assessment results.
6.7.c Practice assessment and improvement processes routinely include assessing and developing skills of the practice’s staff.