Community Medical Center

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**PGY-1 Pharmacy Residency Program**

**Reviewed/revised: October 2020**

Affiliated with the University of Montana

Department of Pharmacy Practice

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1. **General Information**
2. **ASHP Accreditation Standard for Postgraduate Year One (PGY1) Pharmacy Residency Programs**
	1. Available at:

 <https://www.ashp.org/-/media/assets/professional-development/residencies/docs/pgy1-residency-accreditation-standard-2016.ashx?la=en&hash=9FF7C76962C10562D567F73184FAA45BA7E186CB>

1. **Position Description**
2. Introduction: The Pharmacy Residency is a postgraduate year one (PGY1) residency that is located within the Pharmacy Department at Community Medical Center (CMC) and it was originally established as a joint program between The University of Montana Pharmacy Practice Department (UM) and CMC on July 1, 2001. It was the first residency established in Montana. The program is under the direction of the Residency Program Director (RPD) Michael Rivey, M.S., BCPS who serves as Clinical Consultant for Pharmacy Services at CMC. He retired in 2017 as Professor and Chair of Pharmacy Practice at UM, and was recognized as a Professor Emeritus. He also serves as a co-preceptor for some resident rotations. Also involved with program direction is Kevin Cady, Pharm.D. as Director of Pharmacy (DOP) and Clinical Manager at CMC. While Dr. Cady serves the dual roles of DOP and Clinical Manager, his intention is to identify Clinical Leaders within the staff to assist with Clinical Manager duties.

 The residency will be located at CMC, which is a 151-bed community hospital.

1. Requirements: Applicant must have received a Pharm.D. degree from an American Council on Pharmaceutical Education (ACPE) accredited pharmacy school. The applicant also must have, or will soon have, a license to practice pharmacy in Montana at the time of starting the residency. Licensure is critical to completion of the residency requirements and, therefore the resident must have obtained licensure in Montana by September 15th of the residency year. Failure to attain licensure will result in dismissal or at least suspension from the residency (see Licensure & Leave policy).
2. Purpose of program: The purpose of the program is to provide a setting in a community hospital in which the resident will have the opportunity to develop the knowledge, skills, and abilities to progress in the clinical practice of pharmacy in various healthcare settings and to function as a clinical pharmacy preceptor, and possibly a pharmacy faculty member.
3. Outcomes, Goals & Objectives of the residency: The “Goal Statements, Objectives, and Instructional Objectives for Pharmacy Practice Residency Training” by the American Society of Health-System Pharmacists (ASHP) are embraced as those of the program. In that regard, the program recognizes 4 primary outcomes for residency training:
	1. Provide evidence-based, patient-centered medication therapy management in collaboration with the health care team to provide safe and effective patient care
	2. Demonstrate competency in areas that advance practice and improve patient care
	3. Develop leadership and management skills
	4. Design and use effective methods in teaching, education, and dissemination of knowledge

Our residency also has additional focus in the outcome area of advanced development of teaching and learning activities.

1. The resident will have the opportunity to:
	1. Practice personal and professional responsibility and communication skills to patients, other healthcare practitioners, and others.
	2. Further develop his/her drug therapy assessment ability by drug therapy review, physician rounding, patient contact, and interaction with healthcare personnel.
	3. Provide quality patient care by involvement with medical care, provision of drug delivery, pharmacy systems, inservice activities, and quality assurance related to medications.
	4. Develop skills related to the provision of drug information, formulary considerations, pharmacokinetic consultations, clinical recommendations for therapy, and patient medication counseling.
	5. Utilize medical informatics.
	6. Complete a formal Teaching Certificate program administered by UM faculty.
	7. Develop skills related to becoming a preceptor and to pharmacy students completing clinical clerkships, including direct supervision.
	8. Participate in educational activities such as pharmacy student case conferences, physician journal club, staff development, and other interdisciplinary programs.
	9. Conduct a project related to pharmacy practice.
	10. Function as a pharmacy representative in various interdisciplinary committees, such as Infection Control, Pharmacy & Therapeutics Committee, Pain Service, Diabetes Task Force, and others.
	11. Become familiar with investigational drug studies.
2. Duration of Appointment: 1 year period from July 1 to June 30th. The residency may be extended under certain circumstances. See Licensure & Extended Leave Policy (<http://health.umt.edu/pharmacypractice/Current%20Students/Residency%20Opportunities.php>) and Part XI of this section.
3. Benefits of resident position: CMC will be responsible to pay all salary plus benefits costs associated with the position, since the residency is “administrated” from that institution.
	1. annual stipend of $47,500
	2. Paid annual leave (PAL) per the CMC full time position, approximately 160 hours, to include hours for both sick leave and personal days.
	3. professional development and travel expenses of $2375
	4. professional leave as required for professional meetings (travel for future position interviews are not considered professional leave).
	5. other benefits as outlined by CMC, e.g. medical/dental insurance
4. Resident responsibilities: The resident is an important member of the Pharmacy Dept. at CMC. The responsibilities for each resident will differ depending on the demands on the Pharmacy as a whole. (See Resident Portfolio Policy) However, certain aspects of the resident’s responsibilities may be outlined:
	1. Become competent in management of the pharmacy distribution system in order to work independently in any position within the Pharmacy.
	2. Participate in committee activities of the Pharmacy & Therapeutics Committee, Infection Control Committee, Diabetes Task Force, Medication Safety Committee, and others.
	3. Actively participate and promote the clinical pharmacy activities of the Pharmacy. This may be done by involvement in protocol management, such as the Pain Protocol, direct interaction with physicians, nurses and other healthcare workers, and development of new programs as dictated by the Director of Pharmacy, Clinical Manager, Clinical Coordinator, and perhaps staff pharmacists. The resident will independently staff the Anticoagulation or other Ambulatory Care clinic 2 half-days each week. The resident is expected to develop the ability and confidence to independently practice in all clinical settings in the hospital.
	4. Enhance communication and drug information provision provided by the Pharmacy to healthcare workers and patients.
	5. Actively participate in the education of pharmacy students, including functioning as a preceptor.
	6. Develop interpersonal communication skills and become an effective member of a healthcare team approach to patient care.
	7. Complete a project promoting pharmacy practice.
	8. Work in concert with the RPD to enhance the residency experience for future residents.
5. Staffing
6. In order for the resident to gain adequate exposure to all pharmacy services they will have a staffing obligation which includes:
	1. Staffing a pharmacy service every third weekend
		1. Weekend staffing is in addition to the resident’s normal schedule. However, the resident will be given a day off during one of the weeks around the weekend staffing, to avoid 12 straight days of work. The time given will be variable, depending on the rotation the resident is presently completing.
		2. Staffing weekends are not eligible for PPL, but the resident may switch with another pharmacist if it is necessary for them to have one of these weekends off
	2. The resident will independently staff the Anticoagulation/Amb Care clinic 2 half-days each week. The purpose of this staffing is to allow the resident to manage a group of patients on a longitudinal basis throughout their residency year.
	3. Staffing on their current rotation as part of their training when their preceptor deems the resident is qualified. Once qualified, the resident may also may cover for is an absent preceptor if there is not another pharmacist scheduled or available to do so.
	4. Coverage for staffing shortages
		1. Effort is made in the residency to NOT use residents for staffing shortages during clinical rotations
		2. The resident will be limited to filling in a maximum of four shifts that take them away from their rotational experiences in any given month
7. Staffing at this residency is incorporated with the aim to meet the residency objectives, rather than to cover daily pharmacy services.
8. Site of residency: The residency is located at Community Medical Center in Missoula. The hospital is a 151-bed community hospital serviced by private physicians and hospitalists. Areas of practice in the hospital are general internal medicine including infectious disease, adult intensive care, surgery including a significant orthopedic component, and women/children. The hospital has an obstetrics service in Missoula, which is complemented by a neonatal intensive care, pediatric surgery, pediatric intensive care, and general pediatrics services. The hospital is also home to a Rehabilitation Unit, lending to a focus in neurological disorders, and has interventional cardiology services. The hospital also has an affiliated Cancer Care Center. The hospital does not have a significant service component in the areas of nephrology, neurosurgery, or surgical cardiology.

The CMC pharmacy is a mixture of centralized and decentralized unit-based services, with Cerner electronic medical record and Pyxis automation. A wide scope of clinical services is provided, augmented by the association of the clinical faculty from the Univ. of Montana. A pharmacist-managed Pain Protocol is a focus area in the area of Orthopedics. An ICU-based clinical pharmacist position was approved in November 2007. An Ambulatory Care clinical pharmacist position was approved in October 2012, and an additional 1.6 FTE were added in 2015. A decentralized staff clinical pharmacist position was established in the Med-Surg area in 2013. The resident is an important component of the clinical services at this hospital.

1. Residency Graduation criteria
	1. Graduation criteria
		1. The resident must achieve a minimum rating of Satisfactory Progress (SP) on all objectives set forth in the program with the Achieved (ACH) rating being the goal
		2. The resident must provide the following items to the RPD by the end of the residency year
			1. A copy of their major project for the residency in manuscript format
			2. A copy of their Drug Utilization Evaluation (DUE)
			3. Presentation of a minimum of one drug class review, drug monograph, treatment guideline, or protocol to the P&T committee
			4. A copy of successful completion of the Teaching Certificate
		3. The resident must receive a rating of “Achieved for Residency” (ACHR) on 75% of required goals & objectives to graduate from the residency (see Section IV)
			1. This evaluation status may be conferred by a preceptor or more commonly by the RPD on review of cumulative rotation evaluations.
			2. The ACHR is rarely achieved until the second half of the residency for any goal and objective
	2. For dismissal criteria refer to the Resident Corrective Action & Dismissal Policy (<http://health.umt.edu/pharmacypractice/Current%20Students/Residency%20Opportunities.php>)
		1. Failure to complete the residency: A resident may fail to complete the residency on June 30 of the residency year, due to various causes such as significant family or sick leave or failure to attain competence in a residency requirement (Section IV above). In cases of incompletion due to excessive leave and if the RPD and preceptors agree that the resident will successfully complete the requirements (see Resident Corrective Action & Dismissal Policy), the resident will be allowed to finish the residency. However, completion of the residency must occur immediately following the June 30 date, as an extension of the residency year. Compensation for the extra time in the residency likely will not be available. The resident and RPD will meet to develop and mutually agree to expectations and a timeline for completion of the residency. No certificate of completion will be awarded until all requirements of the residency are fulfilled. See Licensure & Extended Leave Policy (<http://health.umt.edu/pharmacypractice/Current%20Students/Residency%20Opportunities.php>)
2. Dismissal of resident from program. A policy regarding Corrective Action & Dismissal should be reviewed for detail on this issue. The resident may be dismissed from the program by the residency administration; however, the resident understands that CMC has the right to immediately remove a resident from its facilities if CMC believes the resident’s actions or behavior threatens patient safety or is inconsistent with CMC policies. Basically, the resident can/will be dismissed from the program by CMC for the following reasons if he/she:
3. Commits a crime that is a felony or significantly impacts his/her ability to practice pharmacy. This would result in immediate dismissal.
4. Fails to progress towards attainment of the residency goals. A written warning of the risk of dismissal which will outlines the reasons for possible dismissal will be given by the RPD to the resident, who will then have 1 month to address the outlined issues.
5. Gross misconduct towards the RPD, any member of the Pharmacy Department, other healthcare worker, or patient will result in a warning and, based on the severity, a written warning as outlined in point (2) above.
6. Chronic absenteeism may be considered to impede progress towards residency goals attainment.
7. Professional liability: The resident actions will be covered to some degree by CMC insurance. However, it is always recommended that a resident obtain personal liability insurance, since he/she will commonly be acting as an independent practitioner.
8. **Residency Educational Outcomes, Goals, & Objectives**
	1. Available at:

<https://www.ashp.org/-/media/assets/professional-development/residencies/docs/required-competency-areas-goals-objectives>

* 1. This residency also includes the Elective Outcome and Goal E6: Teaching and Learning. Objectives related to the objectives of that goal will be fulfilled primarily by completion of the Teaching Certificate.

Available at:

<https://www.ashp.org/-/media/assets/professional-development/residencies/docs/elective-competency-areas-goals-objectives-2014>

1. **Residency Equal Employment Opportunity (EEO) and Diversity**
	1. The Residency adheres to the EEO policy of CMC (and the parent LifePoint Health Company), available at: <https://lifepoint.policystat.com/policy/token_access/a06475f6-95e5-41de-8c97-38eaa9efba0c/>
	2. The selection process of the residency does not give preference to any candidate based on demographic classifications define in the EEO policy (see policy above, or the CMC policy available in Residency Policies in the Pharmacy Appman subfolder). It also does not give preference to the selection of candidates based on the geographic location or the grading system of the pharmacy program attended.
	3. Diversity is encouraged in the residency and past residents completing the program include persons from most regions of the U.S. Also, past residents have included American Indian, Black American, African-born American, and Canadian citizens.
2. **PharmAcademic**
	1. All evaluations and the Customized Residency Plan for this program will be managed through the PharmAcademic system
	2. The RPD will provide training on PharmAcademic during the Orientation to the Residency process at the beginning of the program
3. **Hospital/Pharmacy Information**
	* + 1. **Mission, Vision & Values: CMC**

[**http://communitymed.org/index.php/contact/mission-and-vision/**](http://communitymed.org/index.php/contact/mission-and-vision/)

* + - 1. **Pharmacy Operations**
				1. Policies & Procedures for Community Medical Center and for the Pharmacy Department can be found on the intranet under the Policies tab on the home page with the following link: [**http://10.131.8.99/hpm/**](http://10.131.8.99/hpm/)

a. Hospital security does not allow the P&P link to be accessed from outside the hospital intranet- please ask any questions regarding specific Pharmacy policies & procedures

* The residency will adhere to the ASHP Duty Hour Guideline available at: <https://www.ashp.org/-/media/assets/professional-development/residencies/docs/duty-hour-requirements.ashx?la=en&hash=5AB546BE4986F74D01BA73A8A89ADDB164AA7635>
	+ There is no on-call component to the CMC residency.
	+ As noted, residents will staff every 3rd weekend in the pharmacy, but will be given a day off around their staffing weekend (i.e. they will not be permitted to work 12 days in a row)
* Moonlighting will be permitted under the Pharmacy Resident Duty Hours and Moonlighting Policy and Procedures (<http://health.umt.edu/pharmacypractice/Current%20Students/Residency%20Opportunities.php>) and as outlined in the ASHP Duty Hours Guideline.
	+ Resident duty hour workload including residency hours plus moonlighting will never be allowed to exceed 70 hours in a 1 week period.
* Resident wellness is important to successful completion of the residency and is addressed in a policy regarding Resident Wellness located in the Appman Pharmacy Folder under the Residency Policies.

Community Medical Center also has an Employee Assistance Program (EAP) at <http://communitymed.org/resources/employee-resources/live-well> that can be accessed by the residents.

* + - * 1. Orientation will be completed a required concentrated Learning Experience (LE). Refer to the rotation outline for further details.
				2. Paid Annual Leave (PAL)
1. Timing of PAL submissions
	* 1. Resident PAL requests must be received by the RPD and any affected preceptor 15 days in advance of the requested day off, although requests are encouraged to be submitted as soon as possible.
		2. If there are extenuating circumstances (e.g. family emergency) PAL days will be considered on a case-by-case basis

Holiday coverage

1. The resident will not be responsible for covering the major holidays of New Year’s Day, Memorial Day, July 4th, Labor Day, Thanksgiving, and Christmas as a part of the residency, but these holidays do count as PAL. Other “non-major” holidays not recognized by CMC (e.g. Veterans’ Day, MLK Day, Columbus Day, etc.) that occur during their a resident’s specified working (i.e. weekdays or scheduled weekends) hours will be worked as part of the residency, unless requests are submitted by the resident for PAL and approved by the Pharmacy Manager

**III. Residency Experiences**

**Orientation to the residency**: provided by RPD over first 3-4 weeks of residency

**Required Rotations**

1. Pain Management/Orthopedics

 Preceptor: Dan Lee

1. Internal Medicine I

Preceptors: Catie Walker & Staci Hemmer

1. Hospital Pharmacy Systems initial rotation:

Preceptors: Tuire Reinivaara, Laurie Barten, Tiffany Tierney

1. Internal Medicine II (focus on Preceptor Development in this rotation)

Preceptors: Doug Allington, Staci Hemmer

1. Capstone rotation in last quarter: Resident may do either 1) C2 Clinical Shift rotation or 2) Ambulatory Care II rotation

Preceptors: Mike Rivey or Haley Cote

**Longitudinal Experiences (required)**

1. Hospital Pharmacy Services and Systems (for middle six months of the residency

Preceptors: Tuire Reinivaara

1. Pharmacy Practice Management (9 months long)

 Preceptors: Kevin Cady & Laurie Barten

1. Residency Project

 Preceptor(s): Assigned based on project

1. Education (includes required Teaching Certificate) (9 months long)

Preceptors: Sarah Miller, Jean Carter, Doug Allington,

1. Ambulatory Care

 Preceptor: Nikki Summerday & Haley Cote

**C. Elective Rotations**

1. Critical Care/Pulmonology

 Preceptor: Kristen Johnson

1. Pain Mgmt II

 Preceptor: Dan Lee

1. Emergency Medicine

 Preceptor: TBD

1. Oncology

 Preceptor: Craig Eyer

1. Infectious Disease

Preceptors: Staci Hemmer & Les Whitney, MD

1. Neonatology/Pediatrics

Preceptors: Marcie Mountan & various MDs

1. Ambulatory Care I and II

 Preceptors: Haley Cote & Nikki Summerday

1. Education rotation

Preceptor: Jean Carter & Mike Rivey

* Any required rotation may be taken a second time as an elective

 (max = 8 weeks for any single rotation)

* + - 1. **Concentrated Experiences: elective**
	1. Pediatric Care Camps (Camp Huff n’ Puff, DM Camp, camp Make-A-Dream)
	2. Drug Information Service at UM: elective based on resident’s research & DI skills.

 Affiliated Preceptor: Sherrill Brown

* 1. Certifications

a. BLS (required)

* + 1. ACLS (optional)
	1. P&T drug class review, drug monograph, treatment guideline, or protocol (minimum of one these activities required)
	2. ASHP Midyear Poster Presentation:
		1. Registration deadline: October 1

**Evaluations**

**Evaluation scale definitions (with guidance for performance):**

 **NI** = The resident consistently performs poorly, and/or requires persistent oversight for completion of the objective or goal

* + - * deficient in knowledge or skills required
			* commonly needs assistance to complete the task
			* does not ask questions or take appropriate action to enhance learning of the task or objective

 **SP** = The resident consistently performs well, but may still require some oversight to complete the objective or goal

* + - * has expected/adequate knowledge or skills required
			* sometimes requires assistance to complete task, but does independent work at other times
			* asks good questions or does background work that enhances learning the task or objective
			* additional work on achieving the objective is expected to be required in subsequent rotations/experiences

 **ACH** = The resident consistently completes the objective or goal at a high level while working independently

* + - * is fully able to use the knowledge or skill required
			* rarely requires assistance; preceptor is able to function in a facilitation role
			* the task or skill is mastered by the resident; there is no expectation that further development is needed

**ACHR** = The resident demonstrates the ability to improve on any SP marks from previous evaluations to meet the ACH criteria in subsequent evaluations, or meets the ACH criteria for the goal or objective in multiple practice experiences.

* + - * Consistently performs at the achieve level across several rotations or cumulative evaluations.

**Graduation from the residency requires 75% of goals and 75% of objectives to be met at ACHR level**

Note that the evaluation scales are used in each rotation solely on the basis of the given rotation. A resident may ACH an objective based on expected competence in 1 rotation but only achieve SP for the same objective in a different rotation.

* + - 1. Each rotation will require completion of the following evaluation forms which require co-signatures by the resident, preceptor, and RPD:
* Preceptor evaluation of resident
* Resident evaluation of preceptor
* Resident evaluation of the learning experience
* Resident self-evaluation
	+ - 1. Longitudinal experiences will complete the above evaluations quarterly
			2. Overall assessment of the resident and revision to their Customized Residency Plan (Resident Development Plan) will be conducted on a quarterly basis with the RPD.
			3. See Resident, Preceptor, and Learning Experience Evaluation Process policy

**Preceptor Responsibilities**

1. The preceptor will meet with the resident at the beginning of the rotation. At this time, the preceptor will:
	* + 1. Discuss the preceptor’s specific goals and objectives for the resident throughout the rotation
2. Assess the resident’s baseline knowledge, previous experience, and aptitude
3. Develop an understanding of the resident’s specific goals, interests, and expectations for the rotation
4. The preceptor will fulfill the four preceptor roles as stated in the ASHP Accreditation Standard of instructing, modeling, coaching, and facilitating
5. Throughout the rotation, the preceptor will interact with the resident, providing guidance, assistance, advice, and supervision.
6. Preceptor interaction with the resident will involve teaching pharmacy related and/or patient-related topics. This may include informal lectures, formalized patient care rounding, or other methods of teaching at the preceptor’s discretion.
7. The preceptor will provide ongoing verbal feedback regarding the resident’s progress and performance.
8. If problems arise during the rotation that impairs communication between the preceptor and resident, the RPD shall serve as the liaison for assistance in the matter.
9. The following accommodations shall be required during the time of preceptor absence:
10. When the primary preceptor is absent, the resident shall be supervised by the scheduled pharmacist in the clinical area for that day.
11. If for any reason there is not a pharmacist scheduled for the clinical area in which the resident is rotating through, the primary preceptor must assign a pharmacist that will be available for resident questions and other patient care issues.
12. Upon completion of the rotation, the preceptor shall complete a PharmAcademic resident evaluation form. This evaluation will be completed no later than 10 working days following the end of the rotation (and may be completed by the RPD on behalf of the preceptor). This form is to be discussed with the resident during an evaluation meeting attended by the RPD (with exception of the quarterly longitudinal evaluations). This expectation corresponds to the evaluation procedure followed by the resident at the end of each rotation.
13. The RPD has the responsibility of reviewing each evaluation form. If problems have been expressed or if the above responsibilities have not been fulfilled, the RPD shall discuss these issues with the preceptor immediately following each rotation’s review. If problems persist the program director shall bring the specific issues to the Residency Advisory Committee (RAC) for further review. The committee will then decide upon further action, if necessary.