Starting a PGY1 pharmacy residency program at YOUR institution

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Disclosures

• Nothing to disclose

Objectives

• Describe the need for additional residency training sites
• List resources available to assist with starting a residency
• State the benefits of having residency training available in small or rural hospitals
• Describe an estimated budget necessary to fund a residency program

1st Professional Degrees Conferred

### 2015

**ASHP Health-System Pharmacy Initiative**

- **Objective 4.7**
  - 90% of new pharmacists entering hospital and health-system practice will have completed an ASHP-accredited residency
  - While this goal seems aggressive, imperative to maintain CMS funding
  - Other organizations have equally ambitious goals for direct patient care

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**Capacity - Where should it come from?**

- All academic medical centers: 50%
- Large academic medical centers: 40%
- To meet community residency training, chain stores will need to offer residencies: 89%
- More residences should be developed in non-hospital settings: 90%
- Hospitals and health systems should continue to train the majority of residents vs. developing community pharmacy residencies: 72%

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St. Elizabeth’s Hospital

- 426 licensed beds
- 188 average daily census
- 13,000 admissions / 176,000 outpatient annual
- Medicare patient load 45%
- 15 FTE pharmacists
  - 2 administrative
  - 3 centralized, 9 decentralized
  - 1 resident (as of ASHP visit)

Seattle Grace Mercy West

<table>
<thead>
<tr>
<th>Classification</th>
<th>Item Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Education Expenses</td>
<td>$108,000</td>
</tr>
<tr>
<td>ASHP Midyear</td>
<td>$3,000</td>
</tr>
<tr>
<td>Great Lakes Conference</td>
<td>$2,000</td>
</tr>
<tr>
<td>Teaching and Admin Time</td>
<td>$14,175</td>
</tr>
<tr>
<td>Clinical Director (10% effort)</td>
<td>$16,875</td>
</tr>
<tr>
<td>Clinical Specialist (80% X 1)</td>
<td>$115,690</td>
</tr>
<tr>
<td>Recruitment</td>
<td>$4,000</td>
</tr>
<tr>
<td>Accreditation fees</td>
<td>$1,220</td>
</tr>
<tr>
<td>Grants or awards</td>
<td>Local pharmacy school: n/a</td>
</tr>
<tr>
<td>Medicare Reimbursement</td>
<td>Medicare and Indirect X 45% $154,709</td>
</tr>
<tr>
<td>Staffing contribution</td>
<td>2 residents $50,000</td>
</tr>
<tr>
<td>Total financial impact</td>
<td>2 residents $204,709</td>
</tr>
</tbody>
</table>

Assumptions: Resident salary = $38,500; DOP salary = $130,000; RPD salary = $105,000; CSP salary = $95,000

R U Ready? Be willing to be “creative”

Practical Tips and Considerations

- Qualified RPD, RPC, and preceptors?
- Supportive pharmacy and institutional administration?
- A current position with a residency requirement?
- Current graduate medical education program (i.e. medical residency)?
- CFO or similar with experience in pass-through reimbursement

Residency Program Director (RPD)

- Licensed pharmacist
- ASHP accredited residency completion AND 3 years experience OR
- Five or more years of practice experience AND significant contributions to pharmacy
- Single RPD for multi-site programs
**Residency Preceptors**

- Licensed Pharmacist
- Completion of ASHP-accredited residency AND one year of experience OR
- Three or more years of practice experience
- Training and experience in area of precepting

**Director of Pharmacy**

- Supports residency training
- Embraces residency development as staff development and services development
- Realistic service component (staffing)
- Able to garner support from other hospital administrators

**Its all in the job description**

- Does at least one position require residency?

**Do you have the learning experiences? (or access to them)**

- Six required objectives for an accredited PGY1
  - Manage and improve medication-use process
  - Provide evidence-based, patient-centered medication therapy mgmt with interD team
  - Exercise leadership and practice management skills
  - Demonstrate project management skills
  - Provide medication and practice-related education/training
  - Utilize medical informatics

**Lets develop a rural program....**

- Saint Yourhospital
- 132 licensed beds
- 3 MD and 2 NP hospitalist service
- 9.5 pharmacist FTE
  - 1 Director of Pharmacy
  - 1 Clinical Coordinator (residency trained)
  - 1 Operations Coordinator
- Services include MUE, P & T support, vanc and gent dosing, VTE prophylaxis assess, limited antimicrobial stewardship

**First, what will administration assign to a pharmacy resident?**

- 0.5 vs. 1.0 FTE
- Once accreditation occurs, will pass-through CMS monies return to department?
- Will administration "release" the FTE once accreditation occurs?
- Having these discussions up front is paramount
The Rotations (learning experiences)

- Orientation
- Required or core experiences
- Elective experiences
- Longitudinal experience
- Project experience
- Service experience

<table>
<thead>
<tr>
<th>Month</th>
<th>Rotation</th>
<th>Preceptor of record</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>Orientation</td>
<td>Ops Coordinator or staff</td>
</tr>
<tr>
<td>August</td>
<td>Internal Med I</td>
<td>Clinical Coordinator or CSP</td>
</tr>
<tr>
<td>September</td>
<td>Infectious Disease</td>
<td>CSP or staff with expertise</td>
</tr>
<tr>
<td>October</td>
<td>Cardiology</td>
<td>CSP or outside</td>
</tr>
<tr>
<td>November</td>
<td>Internal Med II</td>
<td>Clinical Coordinator or CSP</td>
</tr>
<tr>
<td>December</td>
<td>Research / DI</td>
<td>DOP, Clin coordinator</td>
</tr>
<tr>
<td>January</td>
<td>Medication Safety</td>
<td>Medication Safety Officer</td>
</tr>
<tr>
<td>February</td>
<td>Administration</td>
<td>DOP</td>
</tr>
<tr>
<td>March</td>
<td>Hospice</td>
<td>Outside</td>
</tr>
<tr>
<td>April</td>
<td>Elective</td>
<td>Outside or based on expertise</td>
</tr>
<tr>
<td>May</td>
<td>Elective</td>
<td>Outside or based on expertise</td>
</tr>
<tr>
<td>June</td>
<td>Elective</td>
<td>Outside or based on expertise</td>
</tr>
</tbody>
</table>

12 months is not that long!

- Orientation
- Internal Medicine I & II
- Medication Safety
- Administration
- Infectious Dz

- Oncology
- Cardiology
- Pain Mgmt
- Hospice
- Critical Care
- DI or research

Non-Traditional Models

- 2 or 3 year extended
- Require current employment within hospital
- Still must use ASHP match
- 3:1 staffing to residency rotation or similar
- Difficult to institute without traditional in place

Must all experiences be “in house” and 1 month?

- No!!!!
- Extended 6-8 week rotations
- Potential Partnerships
  - Nearby institutions with developed pharm services
  - Schools of Pharmacy (how many of you take APPE)
  - Larger teaching hospitals through “resident exchange”
  - i.e. a Rural Rotation
- Tele-precepting with specialists?
  - Could “pay for precepting” pass through to CMS

Current PGY1 Experiences offered “offsite” with affiliated Schools

- Drug information
- Teaching
- Psychiatry
- Pain Management
- Family Medicine
- Cardiology
- Oncology
- Psychiatry
- Pediatrics
- Ambulatory Care
- Modular
- Longitudinal
Recruitment

• Current pre-candidate, candidate, and accredited programs use the matching process
• National Matching Services allows programs to rank candidates and vice versa
• Recruitment processes are evaluated as part of accreditation

Benefits

• Anticipated improved medication use and safety for patients
• Staff development
• Services creation and development
• Potential department expansion
• Recruitment for future openings

Next Steps

• Visit http://www.ashp.org/accreditation/
• Contact established Residency Program Director
• Consider affiliation with School of Pharmacy
• Set a timeline
• Attend a Residency Learning System workshop
• Go recruit!!

Conclusions

• Residency demand is outpacing availability
• Capacity growth may not be feasible in currently accepted models
• Rural pharmacy residencies are viable
  — Financially
  — Educationally
• Help is out there if you’re willing to ask

Recommended Readings

• How to start a residency: What you really need to know (ASHP web)
• Fact sheet on the ASHP pharmacy residency match… (ASHP web)
• CMS audit update August 2010 (ASHP web)
• CMS final rule with comments (ASHP web)
• Preceptor’s Handbook for Pharmacists (Cuellar and Ginsburg)
Post Test Questions:

1. The CMS pass through reimbursement for qualified educational programs is dependent on which of the following:
   a. Number of full time pharmacist FTEs
   b. Number of medicare patients on average (Medicare %)
   c. Salary of the DOP
   d. Affiliation with a School of Pharmacy

2. Smaller hospitals may not seek learning experiences outside of their institution for training residents.
   a. True
   b. False

3. Which of the following most closely coincides with ASHP requirements for Residency Program Directors?
   a. 3 years of experience and an ASHP accredited residency
   b. Completion of a PGY2 residency
   c. Nomination by the pharmacy staff
   d. Nomination by the ASHP accreditation council

4. Non-traditional residency programs (i.e. extended programs) are acceptable and accredited by ASHP.
   a. True
   b. False

5. Residency programs must be accredited by ASHP in order to qualify for CMS pass-through reimbursement of qualified educational expenses.
   a. True
   b. False