

Pharmacy Residency Psychiatric Pharmacy (PGY2)

VA Sierra Nevada Health Care System (VASNHCS)
Reno, Nevada

ASHP ACCREDITED

RESIDENCY PROGRAM GUIDE 2016-2017

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Table of Contents

Responsible Officials for the Administration of the Program	2
PGY2 Pharmacy Residency	6
Purpose Statement	6
Program Outcomes	6
Program Description	6
VASNHCS Mission	6
VASNHCS Pharmacy Service Mission and Vision:	7
Pharmacist Licensure	7
Professional Development	7
General	8
Pay	8
Attendance	8
Annual Leave	8
Authorized Absence	8
Sick Leave	9
Family Friendly Leave (CB)	9
Emergencies	9
Inclement Weather	9
Holidays	9
Dress Code	9
Tour of Duty	9
Qualifications of the Resident, RPD, and Preceptors	9
Confidentiality	12
Duty Hours/"Moonlighting"	12
Chain of Command	12
Program Description	14
Requirements to Receive Residency Certificate	14
Obligations of the Resident to the Program	14
Residency Disciplinary Actions and Dismissal Policy	14
Termination Policy	15
Scope of Practice	16
Pharmacy Residency Board	19
Rotations and Activities	20

Required Rotations	20
Required Longitudinal Experiences	20
Required Meetings and Assignments	20
Electives	20
Learning Experience Preceptors	22
Residency Evaluation Process	24
Objectives Rated as “Needs Improvement” and Remediation	25
Outcomes/Goals for ASHP PGY2 Psychiatric Pharmacy Residency	27
Project Proposal/Manuscript	29
Journal Club Presentation Evaluation Form	31
Drug Information Request Form	33
Extended Leave of Absence	36
Early Commitment Policy	39

VA Sierra Nevada Healthcare System**975 Kirman Avenue
Reno, NV 89502**

____/____/_____

Dear _____,

I would like to take this opportunity to welcome you to the Psychiatric Pharmacy (PGY2) residency program at the VA Sierra Nevada Health Care System (VASNHCS). You are entering a very special portion of your pharmacy career.

Our purpose statement is as follows: *The purpose of the PGY2 psychiatric pharmacy residency at the VA Sierra Nevada Health Care System (VASNHCS) is to produce clinically skilled psychiatric pharmacists able to excel in either a psychiatric-focused or mixed ambulatory care/psychiatric setting. After completion of the residency, the resident will have the capabilities to demonstrate leadership in their future practice site and in the profession, to serve as a resource for medication information, and to be well prepared to pursue board certification in psychiatric pharmacy.*

The year as a resident should be challenging and busy, but through teamwork we will all benefit greatly by your residency training. Many goals will be set and I am fully confident that you will strive to meet or exceed these expectations. Remember, your preceptors and other clinicians are available to assist you in reaching your highest potential. We greatly look forward to working with you, watching your growth, and seeing your further professional development in your pharmacy career.

Sincerely,

Heather M. Mooney, Pharm.D., BCPS, BCPP
PGY2 Residency Program Director

PGY2 Pharmacy Residency

Purpose Statement

The purpose of the PGY2 psychiatric pharmacy residency at the VA Sierra Nevada Health Care System (VASNHCS) is to produce clinically skilled psychiatric pharmacists able to excel in either a psychiatric-focused or mixed ambulatory care/psychiatric setting. After completion of the residency, the resident will have the capabilities to demonstrate leadership in their future practice site and in the profession, to serve as a resource for medication information, and to be well prepared to pursue board certification in psychiatric pharmacy.

Program Outcomes

Educational Outcomes:

Outcome R1: Serve as an authoritative resource on the optimal use of medications used to treat individuals with psychiatric and neuropsychiatric disorders.

Outcome R2: Optimize the outcomes of diverse populations of inpatients and outpatients with a variety of psychiatric and neuropsychiatric disorders and a range of complexity of problems by providing evidence-based, patient-centered medication therapy as an integral part of an interdisciplinary team.

Outcome R3: Demonstrate leadership and practice management skills.

Outcome R4: Demonstrate excellence in the provision of training or educational activities for health care professionals, health care professionals in training, and the public.

Outcome R5: Evaluate and improve the medication-use process in psychiatric and neuropsychiatric patient care areas.

Outcome R6: Conduct psychiatric pharmacy practice research.

Selected Elective Outcomes:

Outcome E3: Where the psychiatric pharmacy practice is within a setting that allows pharmacist privileging, successfully apply for privileging.

Program Description

The VA Sierra Nevada Healthcare System's Psychiatric Pharmacy residency program (PGY2) produces highly skilled psychiatric pharmacists able to excel in either a psychiatric-focused or mixed ambulatory care/psychiatric setting. The residency includes rotations/experiences in outpatient psychiatry, inpatient psychiatry, neurology, substance abuse, CCP case management, CLC/geriatrics, pharmacoeconomics, teaching, as well as electives in areas of interest. Completion of the residency allows graduates to assume positions in a VA setting and to be well prepared to pursue board certification in psychiatric pharmacy.

VASNHC Mission

"Providing World Class Care and Service to America's Heroes"

VASNHCS Pharmacy Service Mission and Vision:

Residents are expected to adhere to the values and mission of the SNVAHCS.

Mission: *To provide the highest quality care to veterans by ensuring safe, effective, and medically necessary use of medications.*

Vision:

- *We will be an essential component of the patient focused Health Care Team.*
- *We will create a practice environment that fosters education, research and professional development.*
- *We will advance the use of innovative technologies to ensure consistent, accurate and reliable medication distribution, education and information systems.*
- *We will provide pharmaceutical services during national emergencies, disasters and other events that adversely affect our veterans.*
- *We will be an employer of choice for pharmacists, pharmacy technicians and supportive staff by providing a compassionate, progressive work environment.*

Pharmacist Licensure

Residents are welcome to pursue licensure in Nevada, but it is not a requirement for working at the VASNHCS. However, it is noted that having a Nevada license would allow a greater number of elective opportunities outside the VASNHCS. **All PGY2 residents are required to be licensed in at least one state of their choice prior to the start of the residency experience and will furnish VASNHCS with a copy of licensure.** Not having at minimum one active licensure will serve as grounds for dismissal from the residency. The residency experience is directly related to the status of licensure.

Professional Development

Professional development of residents is enhanced through membership and participation in local and national organizations. Membership in the American Society of Health-system Pharmacists (ASHP) and the College of Psychiatric and Neurologic Pharmacy (CPNP) is required. Residents are encouraged to consider becoming members of the Nevada Society of Health-Systems Pharmacists (NVSHSP). Residents are strongly encouraged to attend the ASHP Midyear Meeting and as well as the CPNP annual meeting. The resident is expected to present a poster at minimum at the CPNP meeting, and the ASHP Midyear meeting if they choose to attend.

Benefits

General

Parking, laboratory coats, office space, and optional pagers are furnished. Computers are available for use by the residents in the pharmacy resident's office, inpatient and outpatient pharmacy, and clinical areas.

Pay

Residents are paid at the rate of \$44,597 per year. The resident's stipend is based on a 40-hour workweek; however, the very nature of a residency training program is such that additional time is required to complete training assignments. ASHP guidelines for duty hours must be observed (see "Duty Hours"). Funding for travel and related meeting expenses may be reimbursed for meetings.

Attendance

The residency is a full-time temporary appointment consisting of a minimum of 12 months training. The residents' primary professional commitment is to the residency program. Residents are expected to complete additional non-scheduled, non-overtime hours for assignments and projects. The resident is expected to be onsite for at least 40 hours per week and to perform activities related to the residency as necessary to meet the goals and objectives of the program. The resident is expected to report to all scheduled locations for rotations and staffing assignments. When the resident will not be onsite, the program director and preceptor must approve the time off or away and procedures for leave must be followed. At times, the resident will be expected to attend other residency-related conferences or experiences off site during regular working hours. Pharmacy residents may have the opportunity for dual appointment as both GS12 and stipend employees.

If an extended absence occurs (i.e. extended family or sick leave), extension of the residency program may be necessary. The maximum length of extension is not to exceed 3 months, and the program must be completed before September 30th. Opportunity to extend the program with pay will depend on the decision of the VA regarding extending the funding. For more information see [Extended Leave of Absence](#).

Annual Leave

Residents earn annual leave at the rate of 4 hours per 2 week pay period. Annual leave must be requested electronically, as far as possible in advance, via the hospital computer system. An Outlook email should also be sent to the residency program director with the date(s) in the subject line.

Scheduled leave must be APPROVED by the Residency Program Director (RPD). Approval of the preceptor should be obtained prior to submitting the leave request to the Residency Director. The resident must consider what impact the use of leave has on their educational experience before scheduling.

Authorized Absence

Administrative or authorized absence to attend professional meetings is granted at the discretion of the Chief, Pharmacy Service. Authorized absence must be requested electronically at least two weeks prior to the scheduled event via VISTA.

Sick Leave

Residents earn sick leave at the rate of 4 hours per 2 week pay period. Sick leave for scheduled doctor's appointments or elective procedures should be electronically requested two weeks in advance if at all possible. **The RPD and current preceptor should be notified of any unscheduled absence due to illnesses prior to the scheduled tour of duty.** Entry of leave into the computer system should be completed upon the resident's return to work and timekeeper (Nancy Willis and Frances Gonzalez) notified. The RPD may be contacted at home if needed.

Family Friendly Leave (CB)

Family leave or bereavement leave policies indicate that each employee can use a certain amount of family leave each year (104 hours per current policy). Family leave must be requested electronically prior to the planned event or immediately upon employee return if emergency. RPD approval is required. Family leave will be deducted from your sick leave balance.

Emergencies

Personal emergencies/accidents during tour of duty should be reported to the RPD and current preceptor as soon as possible so that appropriate action can be taken.

Inclement Weather

The hospital's inclement weather policy is that **all personnel are required to notify their supervisor of any delay or absence in duty hours due to inclement weather or unsafe conditions. RPD will determine appropriate leave upon arrival to work.** If you are entirely unable to report for duty due to weather conditions, you will be charged the appropriate amount of annual leave.

Holidays

The RPD may excuse the PGY2 resident from working on the paid federal holidays as appropriate.

Dress Code

In brief, the dress code requires professional attire & footwear during normal duty hours Monday-Friday, 8:00 a.m. – 4:30 p.m. (Fridays allow business casual attire including pharmacy polos). A knee length, durable press, long sleeve white lab coat is the general pharmacist uniform, but may not be appropriate in all psychiatric settings; this can be addressed in each rotation. Lab coats will be provided to you during residency training and are to be returned at the completion of training.

Tour of Duty

Tour of duty for all residents is 8:00 a.m. – 4:30 p.m., Monday – Friday. Some rotations may require a change in tour. This 8.5 hour tour of duty allows for a 30 minute lunch break. The RPD and time keeper (Nancy Willis and Frances Gonzalez) must be informed of all changes in tours of duty prior to the change being made.

Qualifications of the Resident:

Applicants are generally interviewed January through the end of February. Each applicant interviews with the RPD and select preceptors. All applicants must have a Pharm.D. and have completed/be enrolled in an ASHP Accredited PGY1 residency or have equivalent experience. Unless in the case of a

PGY1 early committing to the PGY2 program, each applicant must enroll in and be adherent to the requirements of the Resident Matching Program in order to be considered for a resident position.

Qualifications of the Program Director and Preceptors: from ASHP Accreditation Standard

Principle 5: Qualifications of the Residency Program Director (RPD) and Preceptors (The RPD and preceptors will be professionally and educationally qualified pharmacists who are committed to providing effective training of residents.)

Requirements of the residency program director:

5.1 RPDs must be licensed pharmacists with demonstrated expertise in the chosen area of advanced practice, as substantiated by all of the following: (a.) an ASHP-accredited PGY2 residency in the advanced practice area, followed by a minimum of three years of practice experience or equivalent in the advanced practice area [i.e., five years of practice experience in the advanced area with demonstrated mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a PGY2 residency]; (b.) board certification in the specialty [when certification is offered in that specific advanced area of practice]; and, (c.) maintenance of an active practice in the respective advanced practice area.

5.2 RPDs serve as leaders of programs, responsible not only for precepting residents, but also for the evaluation and development of all other preceptors in their programs. Therefore, RPDs must have documented evidence of their own ability to teach effectively in the clinical practice environment (e.g., through student and/or resident evaluations).

5.3 Each residency program must have a single RPD who must be a pharmacist from a practice site involved in the program or from a sponsoring organization.

5.4 A single RPD must be designated for multiple-site residencies or for a residency offered by a sponsoring organization in cooperation with one or more practice sites. The responsibilities of the RPD must be defined clearly, including lines of accountability for the residency and to the residency training site. Further, the designation of this individual to be RPD must be agreed to in writing by responsible representatives of each participating organization.

5.5 RPDs must have demonstrated their ability to direct and manage a pharmacy residency (e.g., previous involvement as a preceptor in an ASHP-accredited residency program, management experience, previous academic experience as a course coordinator).

5.6 RPDs must have a sustained record of contribution and commitment to pharmacy practice that must be characterized by a minimum of four of the following:

- a. Documented record of improvements in and contributions to the respective area of advanced pharmacy practice.
- b. Appointments to appropriate drug policy and other committees of the organization.
- c. Formal recognition by peers as a model practitioner (e.g., board certification, fellow status).
- d. A sustained record of contributing to the total body of knowledge in pharmacy practice through publications in professional journals and/or presentations at professional meetings.
- e. Serving regularly as a reviewer of contributed papers or manuscripts submitted for publication.
- f. Demonstrated leadership in advancing the profession of pharmacy through active service in professional organizations at the local, state, and national levels.
- g. Demonstrated effectiveness in teaching

Requirements of preceptors: (The RPD should document criteria for pharmacists to be preceptors. The following requirements may be supplemented with other criteria.)

5.7 Pharmacist preceptors must be licensed and have completed an ASHP-accredited PGY2 residency followed by a minimum of one year of pharmacy practice in the advanced practice area. Alternatively, licensed pharmacists who have not completed an ASHP-accredited PGY2 residency may be preceptors but must demonstrate mastery of the knowledge, skills, attitudes, and abilities expected of one who has completed a PGY2 residency in the advanced practice area and have a minimum of three years of practice in the advanced area.

5.8 Preceptors must have training and experience in the area of pharmacy practice for which they serve as preceptors, must maintain continuity of practice in that area, and must be practicing in that area at the time residents are being trained.

5.9 Preceptors must have a record of contribution and commitment to pharmacy practice characterized by a minimum of four of the following:

- a. Documented record of improvements in and contributions to the respective area of advanced pharmacy practice (e.g., implementation of a new service, active participation on a committee/task force resulting in practice improvement, development of treatment guidelines/protocols).
- b. Appointments to appropriate drug policy and other committees of the department/organization.
- c. Formal recognition by peers as a model practitioner (e.g., board certification, fellow status).
- e. Serving regularly as a reviewer of contributed papers or manuscripts submitted for publication.
- f. Demonstrated leadership in advancing the profession of pharmacy through active participation in professional organizations at the local, state, and national levels.
- g. Demonstrated effectiveness in teaching (e.g., through student and/or resident evaluations, teaching awards).

5.10 Preceptors must demonstrate a desire and an aptitude for teaching that includes mastery of the four preceptor roles fulfilled when teaching clinical problem solving (instructing, modeling, coaching, and facilitating). Further, preceptors must demonstrate abilities to provide criteria-based feedback and evaluation of resident performance. Preceptors must continue to pursue refinement of their teaching skills.

5.11 Non-pharmacist preceptors (e.g., physicians, physician assistants, certified nurse practitioners) may be utilized for select learning experiences. A pharmacist preceptor must work closely with the non-pharmacist preceptor to select educational goals and objectives for the learning experience, as well as participate actively in the criteria-based evaluation of the resident's performance.

Confidentiality

Development of professional ethics and awareness of a patient's need for confidential and private counseling are important components of your clinical education. Residents will receive training on HIPAA guidelines. It is your responsibility to never mention patients by name at inappropriate times. You should never discuss patients with team members while in stairwells or on elevators. Paperwork containing patient or employee personal information must be placed in appropriate containers for shredding. The U.S. Government computer system is for official use only. The files on this system include federal records that contain sensitive information. All activities on this system may be monitored to measure network performance and resource utilization; to detect unauthorized access to or misuse of the system or individual files and utilities on the system including personal use; and to protect the operational integrity of the system. Use of this system constitutes your consent to such monitoring. Misuse of or unauthorized access to this system may result in criminal prosecution and disciplinary, adverse, or other appropriate action.

Duty Hours

Residents, program directors, and preceptors are required to follow ASHP Pharmacy Specific Duty Hour Requirements.

<http://www.ashp.org/DocLibrary/Accreditation/Regulations-Standards/Duty-Hours.aspx>

Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do not include reading and preparation time spent away from the duty site.

1. Duty hours must be limited to 80 hours per week, averaged over a four-week period.
2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period.
3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods.

Residents are responsible for tracking duty hours. If a violation occurs, this must be documented and reported immediately.

“Moonlighting”

“Moonlighting” at VASNHCS or outside of VASNHCS is permitted, but **must meet the duty hour requirements**. Resident “moonlighting” hours will be documented in PharmAcademic at regularly scheduled intervals. If the resident, preceptor, or Residency Program Director finds that the resident’s judgment is impaired or they are unable to meet the requirements of the program, individual adjustments to permitted “moonlighting” hours may be made. It is essential to ensure that the goals of the program are being met and that the resident and/or patient's welfare is never compromised by either "moonlighting" or reliance on the resident to fulfill service obligations.

Source: Pharmacy Specific Duty Hours Requirements for the ASHP Accreditation Standards for Pharmacy Residencies

Pharmacy Residency “Chain of Command”

Conflict in the workplace is very common and needs to be dealt with in a healthy, productive fashion. When conflicts go unaddressed, they can have a negative impact on productivity and teamwork. Because of this, conflict resolution is a necessary component of the workplace. Successful conflict resolution requires a mature, non-confrontational approach and should always begin with the involved parties. If the resident is unable to resolve a conflict with the involved party, the residency chain of command should be employed to effectively communicate and resolve conflicts that may arise during the residency year. It is the resident’s responsibility to explain, understand, and utilize the appropriate chain of command within the department. The residency chain of command generally consists of:

1. Preceptor
2. Residency Program Director
3. Chief of Pharmacy
4. National Director of Pharmacy Residency Programs and Education

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Program Description

This residency is a 12 month program designed to meet the standards set forth by the ASHP for Psychiatric Pharmacy Residencies(PGY2). Completion of the residency leads to a Certificate of Residency.

Requirements to Receive Residency Certificate

- Satisfactory completion of all rotations and required activities. If a rotation is not satisfactorily completed, appropriate remedial work must be completed as determined by the preceptors and program director
- Completion of a minimum of 12 months training, including paid time off
- Compliance with all institutional and departmental policies
- Must receive Achieved for Residency (ACHR) on all critical goals and objectives
- Minimum Satisfactory Progress (S/P) on all other goals and objectives at the end of the residency
- Completion of all assignments and projects as defined by the preceptors and Residency Program Director prior to completion of the residency program. Required work products will not be accepted if submitted more than one month after the completion of the residency program
- Completion of a residency project with a **manuscript suitable for publication submitted in the journal format of choice to the Residency Program Director** no later than the day of the last day of residency unless granted up to one month extension at discretion of the Program Director
- Attend at least one professional state or regional meeting and one national meeting (must be pharmacy-related) as approved by the RPD and Chief of Pharmacy
- Planning and participating in Pharmacy Week (usually third week in October)
- Participate in recruiting activities for the residency
- Contribute to optimal patient care and achieve the mission and goals of VASNHCS and the Pharmacy Service

Obligations of the Resident to the Program

- The resident will be committed to attaining the program's educational goals and objectives as specified by ASHP (<http://www.ashp.org/DocLibrary/Accreditation/Regulations-Standards/RTPObjPsychiatric032608.pdf>) and will support the organization's mission and values.
- The resident's primary professional commitment must be to the residency program.
- The resident shall be committed to the values and mission of the training organization.
- The resident shall be committed to requesting and making active use of the constructive feedback provided by the residency program preceptors.

Residency Disciplinary Actions and Dismissal Policy

It is not expected that any disciplinary actions will be required during the residency. However, criteria have been established to avoid making an unpleasant situation more difficult. Each resident is expected to perform in an exemplary manner. If a resident fails to achieve the requirements of the program, a performance improvement plan will be implemented and disciplinary action will be taken as necessary.

Examples of inadequate or poor performance include dishonesty, repetitive failure to complete assignments, being late for clinical assignments, abuse of annual and/or sick leave, violating VASNHCS or VA policies and procedures, patient abuse, and violating ethics or laws of pharmacy practice. The following sequence of disciplinary actions are outlined:

1. *Minor or initial failure to adhere to requirements will result in an **initial verbal counseling** by the primary preceptor or the Residency Program Director. A note stating a verbal counseling has occurred will be sent to the Residency Board. If a resident is late to work more than one time the resident will be considered absent without leave and a pay reduction will be assessed for the time missed.*
2. *For repeated or more severe incidents, the Residency Program Director or Residency Board will give residents a **formal written warning** of failure to meet the requirements of the residency program. A list of actions and/or additional assignments required to continue in the program will be determined by the Residency Board and must be signed by the resident. The board will follow the resident's compliance with the required actions. Failure with compliance may lead to the dismissal of the resident from the program. Failure to maintain licensure will result in dismissal of the resident from the program.*
3. *For identified Needs Improvements (NIs) on summative evaluations, immediate RPD involvement is required. A written **Performance Improvement (PI) plan** will be created with routine check-in (i.e. monthly) regardless of whether improvement is noted to ensure there is no reverting or new issues that arise and to allow the resident to gauge performance and offer adequate time for remediation if necessary. See page 25 for more details.*
4. *Failure to comply with the required actions set forth by the Residency Board will be documented in writing by the preceptor, Residency Board, or Residency Director. The Residency Board, Chief of Pharmacy, and Residency Program Director will decide whether dismissal is necessary after reviewing the situation with the resident and preceptor. If dismissal is necessary the proper process will be initiated.*

Termination Policy

A PGY2 Pharmacy resident may be terminated at the discretion of the Chief of Pharmacy and Residency Program Director for failure to meet the program objectives and requirements as outlined in the PGY2 Pharmacy Residency Manual or failure to meet the terms of employment of the Reno VA Medical Center set forth in the Medical Center's Standards of Ethical Conduct and Related Responsibilities of Employees.

Scope of Practice

What is a Scope of Practice or Collaborative Practice Agreement?

Clinical pharmacy specialists may have a range of practice privileges that vary with their level of authority and responsibility. The specific practice should be defined within a scope of practice document or protocol developed by the health care institution. This protocol should define the activities that pharmacists will provide within the context of collaborative practice as a member of the interdisciplinary team, as well as any limitations that may be needed. Quality of care review procedures and processes to assure professional competency should also be included in the scope of practice.

At VASNHCS, all clinical staff (excluding physicians) that prescribe treatment in the medical record (dietitians, nurses, pharmacists, podiatrists, physician assistants, social workers, physical therapists, audiologists, speech/language pathologists and respiratory therapists) will function under a scope of practice approved by the Chief of Staff. Pharmacy Service has a peer review committee to assure high quality care is provided and that clinical pharmacy specialists are qualified to perform under their scope of practice.

In order to be granted prescriptive authority, clinical pharmacy specialists must possess:

1. A current state license, and
2. A Pharm.D. or M.S. degree (or equivalent). Examples of equivalent qualifications include (but are not limited to):
 - a. Completion of a PGY1 American Society of Hospital Pharmacists accredited residency program,
 - b. Specialty board certification, or
 - c. Two years of clinical experience.

VASNHCS Pharmacy Service has clinical pharmacists practicing in a wide variety of clinical settings and has various protocols in place to cover these activities.

Upon receiving a pharmacist's license, a resident can perform any key function typically performed within a pharmacist's scope of practice. All activities must be accomplished within the guidelines, policies and procedures set forth by the hospital and Pharmacy and Therapeutics Committee. Residents will document their activities in the patient medical record with a progress note that will need to be cosigned by the preceptor. Based on policy, PGY1 residents will not be individually scoped and will perform clinical functions under their preceptor's scope with co-signature requirement. PGY2 residents have the opportunity to apply for and obtain a scope of practice in their specialty area.

Excerpt from PBM Field Guidance Clinical Pharmacist Scope of Practice:

Clinical Pharmacist Scope of Practice (SOP) must meet requirements as outlined in VHA Directive 2008-043 and VHA Directive 2009-014. The clinical pharmacist scope of practice is obtained through careful review of a pharmacist qualifications, training, and demonstration of skills and allows for collaborative medication management. Collaborative medication management entails an agreement wherein pharmacists may perform all facets of comprehensive medication management which includes initiate, modify, and continue medication regimens, order related laboratory tests and diagnostic studies, perform physical measurements and objective assessments, take

independent corrective action for identified drug-induced problems and order consults (e.g., dietician, social work, specialty provider), as appropriate, to maximize positive drug therapy outcomes as defined in their scope of practice.

*For purposes of this guidance, it is important to understand the definition for clinical pharmacist with a scope of practice. A **clinical pharmacist with a scope of practice** is an individual who provides direct patient care and functions at the highest level of clinical practice, working with a high level of autonomy and independent decision-making within the parameters of their scope of practice, as defined by the individual medical facility, and performs functions as described in VHA Directive 2008-043 and this guidance. A clinical pharmacist with a scope of practice includes the clinical pharmacy specialist, however a scope of practice may be included in the responsibilities of all levels of clinical pharmacists depending on their assignment as outlined in VA Handbook 5005/55.*

The scope of practice permits a high level of autonomy and independent decision-making when performing the authorized duties but requires collaboration with the healthcare team for the overall care of the Veterans. In performing the authorized duties, the clinical pharmacist is responsible and accountable for the patient care managed under the clinical pharmacist's scope of practice. To be granted prescriptive authority and responsibility, the clinical pharmacist must have experience and expertise in the practice areas and functions, including, but not necessarily limited to, medication management of patients with defined diagnoses, management of medication-related adverse events, ongoing and acute medication monitoring, and collaboration with other healthcare providers for management of new diagnoses.

When Is a Scope of Practice Required?

A scope of practice is required for all Clinical Pharmacy Specialists, as well as any other licensed positions in which the clinical pharmacist has direct patient care responsibilities and serves as a non-physician provider to initiate, modify, extend or discontinue medication therapy with their name placed on the order or prescription. Direct patient care for the purpose of this guidance refers to patient care functions which are carried out collaboratively or autonomously by a clinical pharmacist in an advanced practice role and are above and beyond those functions considered to be routine part of a VA clinical pharmacist's duties.

Activities that require a scope of practice include, but are not limited to, the following:

1. Executing therapeutic plans utilizing the most effective, safest, and most economical medication treatments.
2. Ordering, subsequent review and interpretation of appropriate laboratory tests and other diagnostic studies necessary to monitor, support, and modify the patient's drug therapy.
3. Prescribing medications, devices and supplies to include: initiation, continuation, discontinuation, monitoring and altering therapy.
4. Ordering and administering vaccines as necessary for the provision of pharmaceutical care.
5. Taking independent corrective action for identified drug-induced problems.
6. Ordering consults (e.g., dietician, social work, specialty provider), as appropriate, to maximize positive drug therapy outcomes.
7. Obtaining and documenting informed consent for treatments and procedures that require consent for which the clinical pharmacist is responsible, including those where the clinical

pharmacist is the prescriber of a treatment that requires consent or when they are providing medication management services on behalf of the original prescriber.

When Is a Scope of Practice Not Required?

Patient care activities are included in the role of all clinical pharmacist positions, as appropriate. All clinical pharmacists can perform duties that are considered routine. However, depending on the nature of the function or the manner in which it is performed, the activities could result in the performance of patient care, requiring a scope of practice. A list of examples of activities that generally are considered routine clinical pharmacist duties that do not require a scope of practice can be found in Attachment B. Medication prescriptive authority requires a scope of practice as set forth in VHA Directive 2009-014.

The Facility may develop medical center policy that allows clinical pharmacists to provide services on behalf of the prescribing provider without requiring a scope of practice (or placing the pharmacist's name on the prescription). In these instances, the policy must identify the VA provider's name to be placed on the prescription and utilized for policy orders entered by the clinical pharmacist and may include circumstances such as:

- Orders for non-medication items such as diabetic supplies (e.g. test strips), nutritional supplements (e.g. Jevity, Ensure), ostomy supplies, and other supply items required for patient care after proper patient assessment,
- Providing a "bridge" supply of medications for Traveling Veterans, and
- Therapeutic substitutions or interchanges of medications or other activities (e.g. recalled medications) as approved by Pharmacy and Therapeutics Committee or medical staff governing body.

Note: Whenever medical center policy is developed to allow these services, it is important that policy be paired with competency assessment as well as ongoing quality assurance for the process.

References

1. VHA Directive 2008-043 – Scope of Practice for Pharmacists with Direct Patient Care.
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1732
2. VHA Directive 2009—014 – Establishing Medication Prescribing Authority for Clinical Pharmacy Specialists
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1852
3. VHA Handbook 1100.19 – Credentialing and Privileging.
http://vaww1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1806
4. VHA Directive 2012-303-Credentialing of HealthCare Professionals.
http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2815
5. PBM Guidance Professional Practice Evaluations for Pharmacists with a Scope of Practice, May 2, 2011. Professional Practice Evaluations for Pharmacists with a Scope of Practice
6. PBM Guidance Scope of Practice Recommendations for Pharmacy Residents, January 17, 2013. Scope of Practice Recommendations for Pharmacy Residents.

Pharmacy Residency Board

The Pharmacy Residency Committee, chaired by the RPD and composed of residency preceptors, is established for these goals:

1. To facilitate that each resident meets the goals and objectives of the PGY1 or PGY2 Pharmacy Residency Program over the course of the year.
2. To assess and improve the residency program, including the program manual, required activities and elective offerings.
3. To assure that the residency meets and surpasses the standards as set by the ASHP and the Department of Veterans Affairs.
4. To foster the resident's professional and personal growth.
5. To assure a balance between clinical activities/learning and administrative/staffing is maintained throughout the residency year.

The Board will meet at least quarterly to review quarterly reports, rotation evaluations, project proposals, and to evaluate resident project progression and implement a resident-specific customized plan. Residents are asked to meet with the residency board quarterly to review their evaluations, as well as discuss the residents' progress, areas for improvement, project, career goals and feedback about the residency program. The Board will also approve/disapprove the chosen electives for each resident.

Board members take an active role in the professional development of the residents.

Residents are expected to take an active role in meeting their program goals and assessing their rotations. Each resident is expected to perform in an exemplary manner. If a resident fails to achieve the requirements of the program, a performance improvement plan will be implemented and disciplinary action will be taken as necessary, as explained in the [Residency Disciplinary Actions and Dismissal Policy section](#).

Rotations and Activities

In order for the resident to attain competency in the levels of practice as required by the pharmacy practice standards, residents will complete the following:

Required Rotations

Orientation (1 month)

Inpatient Psychiatry 1 and 2(1.5 month #1, 1 month #2)

Outpatient Psychiatry 1 and 2 (1.5 month #1, 1 month #2)

Neurology+Substance Abuse+PPRC/CCP Case Management (3 months)

CLC/Geriatrics (1 month)

Elective 1 (1 month)

Elective 2 (1 month)

Required Longitudinal Experiences

Pharmacoeconomics/Leadership

Teaching

Project

½ day Clinic

Scope of Practice (Concentrated)

Required Meetings and Assignments

- Local P&T Meetings (unless excused by RPD prior to the meeting) –
 - Resident assists in taking minutes for P&T and contribute to P&T pearls as assigned
- Mental Health Task Force (VISN 21 meeting)
- Weekly Staff Meetings (Thursdays at 8am)
- One national professional meeting (must be pharmacy-related)
- Help plan Pharmacy Week (Usually 3rd week in October)
- Practice Management/Drug Policy – Meeting with leadership as needed including: Resident Leadership Conference (Every 2nd Wed and 4th Friday at 3:30pm)
- Assigned PharmAcademic evaluations as well as initial and quarterly self-evaluations

The resident may be excused from some of these meetings with permission from the residency director if they conflict with scheduled patient care activities on assigned rotations.

Electives

Electives may be selected from well-established pharmaceutical care areas or developed for unconventional areas.

Any of the core/required areas may be selected as an advanced elective rotation. The following are other established electives:

Suicide Prevention

HIV/Hep C Clinic

Ambulatory Care

Academic Detailing

Please notify the RPD if you are interested in developing any additional electives.

The resident is responsible for arranging all electives with the preceptor and the RPD. It is recommended that this be accomplished as early as possible in the residency year to facilitate planning of all involved. Chosen electives for each resident will be reviewed and approved/disapproved for each resident by the Residency Board Committee.

Learning Experience Preceptors

Learning Experience	Preceptor(s)/Contacts	Contact Information
Orientation	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP	Ext 2950 ASCOM Ext 4795
Inpatient Mental Health 1 and 2	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP Mark Broadhead MD	Ext 2950 ASCOM Ext 4795
Outpatient Mental Health 1 and 2	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP	Ext 3540
Neurology	Amy Ferguson PharmD BCACP CDE Vanessa Vaupel PharmD BCPS John Peacock MD	Ext 6364
Substance Abuse	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP Mary Powers RN Garen Mirzaian MD Brian Howery LCSW	Ext 2950 ASCOM Ext 4795
CCP Case Management	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP Marianne Cascio NP	775-250-4757 (cell) 775-842-1397 (cell)
CLC/Geriatrics	Dawn Currie, PharmD., BCPS Tara Reddy, PharmD., BCPP	Ext 5017
Teaching (longitudinal)	Kelly Krieger PharmD	
Pharmacoeconomics (longitudinal)	Amneet Rai PharmD.	Ext 5866
½ Day Outpatient Clinic (longitudinal)	Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP	Ext 2950 ASCOM Ext 4795
Project (longitudinal)	Mostaqul Huq PharmD PhD Kelly Krieger PharmD Heather Mooney PharmD, BCPS, BCPP	Ext 2720
Elective 1	TBD	TBD
Elective 2	TBD	TBD

PGY2 Pharmacy Residency Program Residency Evaluation Process

Evaluations are important for maximal growth during residency. **Before the program begins**, each resident completes an **initial self-evaluation**. This allows the RPD and Residency Board to tailor the residency experience to the individual resident's desires, needs, and experiences. Each resident's **individualized residency** training program and evaluation process is entered into a security protected on-line computerized program. The residency director has entered all documents and determined time frames for scheduled rotations, appropriate preceptors and evaluation documents. Descriptions of each rotation experience are available which include: a brief descriptor, goals and associated objective to be formally taught and evaluated during this experience, learning activities to facilitate achievement of the goals and objectives, schedule, and designated meetings/responsibilities.

Residents are assigned to preceptors for training and guidance. Preceptors will meet with the resident on a regular basis and review the resident's accomplishments. **Midway through a rotation** the preceptor will determine if the resident is likely to meet all goals and objectives of the rotation. If the resident has not met the goals and objectives necessary to pass the rotation, the preceptor will discuss this with the resident so corrective actions can be taken. If the resident does not meet these goals and objectives by the end of the rotation, the board will discuss and plan the course of action at that time. **During the rotation** feedback will be given by the preceptor as projects and tasks are completed. **Formative evaluations** may occur as daily feedback; verbal or written. Examples of written evaluation can be signing progress notes and addendums, journal club or presentation evaluations, corrected minutes and agendas etc. The resident will also be expected to complete at least one formative self-evaluation per rotation. Our goal is for the resident to get the most out of their experience and to grow as much as possible during the PGY2 year. The resident is expected to regularly request feedback from preceptors, and is expected to make active use of the feedback given.

Summative evaluations occur at the **end of each Learning Experience** if 6 weeks or shorter or quarterly for those that are longitudinal experiences. **At the conclusion of each rotation**, required evaluations will be completed in PharmAcademic (formerly ResiTrak) online through the PharmAcademic website.

Each resident is asked to give an honest appraisal of the preceptor and the rotation. Once the preceptor and the resident have completed evaluations they will be discussed. After discussion the preceptor and resident will sign the evaluation. Evaluations will be reviewed and deficiencies and/or disciplinary actions that are needed will be addressed by the Residency Board. These are then signed by the Residency Director and filed.

In addition, **at the end of each quarter** the resident's entire program evaluation is done by the Residency Director with input from the Residency Board. A review and discussion between the resident and Residency Director is documented and an individualized plan is developed to accommodate changes in the resident's learning experience based on their or the preceptors requests. Once goals for the program are

achieved they need not be evaluated again, unless it is felt to be beneficial for the resident. If satisfactory progress is made the goals continue to be evaluated.

Quarterly evaluations are done by the Residency Board and are presented to the resident. The evaluation involves identifying any objective evaluated that has been rated as "Needs Improvement". Specific suggestions for improvement are made. In addition, strengths and areas of improvement are identified and the **residency experience is tailored to the resident's needs.**

The resident is also asked to complete a quarterly self-assessment similar in nature to the initial assessment to assist in this individualization. A quarterly self-evaluation is an important component of the residency program. These will be completed in October, January, April, and June. The evaluation should be introspective of where the resident feels he/she is progressing. The self-evaluation should be related to the initial plan that was submitted in June. These evaluations will be reviewed by the RPD. Changes in experiences may be recommended by the RPD/ Board to help residents attain the goals. In addition, the residents will self-evaluate the same goals and objectives that the preceptor is evaluating at the end of the Learning Experience. The preceptors will also self-evaluate their teaching skills.

At the end of the residency year, residents will be asked to complete a final self-evaluation as well as an evaluation of the program and overall residency experience. This will take place through the completion of two forms – a final quarterly self-evaluation and an outgoing resident survey. The resident will also receive a final evaluation by the Residency Board that will be presented to the resident in a format similar to the above quarterly evaluations.

Meaning of Objective Ratings

Achieved

The resident has fully accomplished the educational goal for this particular learning experience. No further instruction or evaluation is required.

Achieved for Residency

This is reserved for the RPD to decide and may be left until the end of residency for some items, as some may require multiple evaluations.

Satisfactory Progress

This applies to an educational goal whose achievement requires skill development in more than one learning experience. In the current experience, the resident has progressed at the required rate to attain full achievement by the end of the program.

Needs Improvement

The resident's level of skill on the educational goal does not meet the preceptor's standards of either "Achieved" or Satisfactory Progress," whichever applies.

Objectives Rated as “Needs Improvement” and Remediation

Needs Improvement on Midpoint or Formative Evaluation

Preceptors are encouraged to provide verbal feedback during the rotation in addition to written feedback in PharmAcademic. If the preceptor has provided initial verbal feedback and the resident is not meeting “satisfactory progress” for a specific goal or objective, the preceptor should document a formative evaluation as soon as possible and discuss with the resident. Especially for longitudinal rotations in which evaluations are scheduled quarterly, waiting until the scheduled summative evaluation will result in a delay and frustration for both the resident and preceptor. Formative or mid point evaluations that include a “needs improvement” must include a documented action plan in PharmAcademic that will target “satisfactory progress” by the end of the learning experience. The preceptor will notify the RPD regarding the evaluation and action plan. If needed, the preceptor and RPD will meet to discuss further actions.

Needs Improvement on Less than Two Summative Evaluations

If a preceptor determines that a resident still needs improvement for selected goals and objectives by the end of the rotation, the preceptor will meet with the RPD PRIOR to the end of the rotation and PRIOR to meeting with the resident. The preceptor and RPD will determine how the objective will be addressed on future rotations and will decide if a warm-hand off is needed between the current and upcoming preceptor. The RPD will determine if any modifications are necessary to future rotations to ensure satisfactory progress. The current preceptor will meet with the resident to provide the summative evaluation.

Needs Improvement for the Same Objective on More than One Summative Evaluation

If a resident receives “needs improvement” for the same objective on more than one summative evaluation, a formal remediation process will be implemented to assist the resident in addressing the areas needing improvement. The RPD will meet with the preceptors and resident to discuss the evaluations. Based on this discussion, the RPD and resident will develop and document an action plan in PharmAcademic. Example items in the action plan include goal-setting, additional assignments, timelines, and frequent follow up meetings. The RPD will determine if any modifications are necessary to future rotations to ensure satisfactory progress. Modifications may include extending or repeating specific learning experiences and elimination of elective learning experiences to provide additional time for remediation.

Needs Improvement on More than 3% of Required Objectives

If at each quarterly meeting, a resident has received “needs improvement” for more than 3% of required program objectives on summative evaluations, a formal remediation process will be implemented to assist the resident in addressing the areas needing improvement. The RPD will meet with the preceptors and resident to discuss the

evaluations. Based on this discussion, the RPD and resident will develop and document an action plan in PharmAcademic. Example items in the action plan include goal-setting, additional assignments, timelines, and frequent follow up meetings. The RPD will determine if any modifications are necessary to future rotations to ensure satisfactory progress. Modifications may include extending or repeating specific learning experiences and elimination of elective learning experiences to provide additional time for remediation. If the resident still receives “needs improvement” for more than 3% of required program objectives on summative evaluations after completion of a formal remediation process, or if the resident is unable to complete the remediation process, the RPD may recommend termination from the program.

PharmAcademic link: <https://www.pharmacademic.com/>

Outcomes/Goals for PGY2 Psychiatric Pharmacy Residency

Required ASHP Accreditation Outcomes/Goals

Outcome R1: *Serve as an authoritative resource on the optimal use of medications used to treat individuals with psychiatric and neuropsychiatric disorders.*

	Outcome R1: <i>Serve as an authoritative resource on the optimal use of medications used to treat individuals with psychiatric and neuropsychiatric disorders.</i>
Goal R1.1	Select core biomedical literature resources appropriate for psychiatric pharmacy practice.
Goal R1.2	Contribute the psychiatric pharmacy specialist's perspective to decisions about technology and automation systems.
Goal R1.3	Establish oneself as an organizational expert for pharmacy-related information and resources regarding psychiatric and neuropsychiatric disorders.
Goal R1.4	Provide concise, applicable, comprehensive, accurate, and timely responses to requests for drug information pertaining to the care of individuals with psychiatric and neuropsychiatric disorders.
Goal R1.5	Assist the organization in achieving compliance with accreditation, legal, regulatory, and safety requirements related to the use of medications used in the care of individuals with psychiatric and neuropsychiatric disorders (e.g., The Joint Commission requirements; ASHP standards, statements, and guidelines; state and federal laws regulating pharmacy practice; OSHA regulations).
	Outcome R2: <i>Optimize the outcomes of diverse populations of inpatients and outpatients with a variety of psychiatric and neuropsychiatric disorders and a range of complexity of problems by providing evidence-based, patient-centered medication therapy as an integral part of an interdisciplinary team.</i>
Goal R2.1*	Establish collaborative professional relationships with members of the outpatient and inpatient psychiatric interdisciplinary teams.
Goal R2.2*	For a caseload of patients with psychiatric and neuropsychiatric disorders, triage and prioritize the delivery of patient-centered medication therapy.
Goal R2.3	Establish collaborative pharmacist-patient-caregiver relationships.
Goal R2.4*	Collect and analyze patient information.
Goal R2.5	When necessary, make and follow up on referrals/consults for individuals with psychiatric and neuropsychiatric disorders.
Goal R2.6	Design evidence-based therapeutic regimens for individuals with psychiatric and neuropsychiatric disorders.
Goal R2.7	Design evidence-based monitoring plans for individuals with psychiatric and neuropsychiatric disorders.
Goal R2.8	Recommend or communicate regimens and monitoring plans for individuals with psychiatric and neuropsychiatric disorders.
Goal R2.9	Implement regimens and monitoring plans.
Goal R2.10*	Evaluate the progress of individuals with psychiatric and neuropsychiatric disorders and redesign regimens and monitoring plans.
Goal R2.11	Communicate ongoing patient information to facilitate continuity of care.

Goal R2.12*	Document direct patient care activities appropriately.
	Outcome R3: Demonstrate leadership and practice management skills.
Goal R3.1	Exhibit the ongoing development of essential personal skills of a psychiatric pharmacy practice leader.
Goal R3.2	Contribute to the leadership and management activities within the psychiatric pharmacy practice area.
Goal R3.3	Exercise practice leadership.
	Outcome R4: Demonstrate excellence in the provision of training or educational activities for health care professionals, health care professionals in training, and the public.
Goal R4.1*	Provide effective education and/or training to health care professionals and health care professionals in training.
Goal R4.2	Design and present education programs to the public that center on mental health improvement, wellness, and disease prevention.
Goal R4.3	Contribute to mental health screening programs.
	Outcome R5: Evaluate and improve the medication-use process in psychiatric and neuropsychiatric patient care areas.
Goal R5.1	Contribute to the maintenance of the organization's formulary for medications used in individuals with psychiatric and neuropsychiatric disorders.
Goal R5.2	Make recommendations for the use of guidelines in the care of individuals with psychiatric or neuropsychiatric disorders.
Goal R5.3	Identify opportunities for improvement of aspects of the organization's medication-use system affecting individuals with psychiatric and neuropsychiatric disorders.
Goal R5.4	Recommend quality improvement changes to aspects of the organization's medication-use system affecting individuals with psychiatric and neuropsychiatric disorders.
	Outcome R6: Conduct psychiatric pharmacy practice research.
Goal R6.1*	Conduct a psychiatric pharmacy practice research project using effective project management skills.
	Elective Outcomes for Psychiatric Pharmacy PGY2 Outcome E3: Where the psychiatric pharmacy practice is within a setting that allows pharmacist privileging, successfully apply for privileging.
Goal E3.1*	Successfully petition for privileging as a psychiatric pharmacy practitioner.

Goals marked with an (*) are defined as [critical goals](#)

Project Proposal/Manuscript

Implementation/Data Collection

The resident must receive approval from the Residency Board prior to initiating the project. The project advisor and program director must be apprised of the progress and all problems encountered in a timely manner. The resident must meet with the project advisor at least monthly to discuss the progress and report on progress to the program director.

The Project Resources folder on PharmShare includes many resources with the proper forms, including a form for the IRB to differentiate a QI project from research. The research pharmacist is also an excellent resource, and is expected to be involved in the design of the project, and other areas where necessary.

Presentation

For both the proposal and the presentation of the results, the resident must demonstrate to the Residency Board a thorough understanding of the topic, the methods, any shortcomings of the study and the results and conclusions supported by the project. The resident will create a poster to present at a national meeting and will also create a presentation. The prepared presentation should be 15 minutes with the remainder of the time left for questions and answers (5 minutes). Audiovisuals should be used to enhance the presentation as appropriate with handouts of the presentation provided to facilitate feedback from preceptors.

Quality

The resident must meet scientific standards for quality in all aspects of the project. The resident may be required to repeat any or all aspects of the project if the standards are not met. The resident will not receive a residency certificate if the project is not completed or if a final paper suitable for publication is not submitted. Suitability will be determined by the residency advisor and program director with the advice of the Residency Board.

Journal Club Presentation Evaluation Form

Presenter: _____ **Date:** _____

1. REVIEW OF THE PERTINENT PRIMARY LITERATURE 1 2 3 4 5

Identifies other recent clinical trials/studies of the same drug/procedure
Primary literature is condensed and is correctly summarized
Elaborates on any major attributes or deficiencies of the available data
If there is a lack of literature/studies for review, this is stated

2. PRESENTATION OF THE ARTICLE 1 2 3 4 5

Explains: Study Goal
Methodology
Results

3. EVALUATION OF THE ARTICLE 1 2 3 4 5

Identifies strengths and weaknesses of the methodology of the trial/study
Assesses and critiques the statistical analysis
Draws own conclusions and contrasts them with authors(s)
The conclusions made by the presenter about the trial are correct

4. ABILITY TO ANSWER QUESTIONS 1 2 3 4 5

Answers are logically presented
Answers are accurate
Presenter can think on his/her feet (theorize if necessary)

5. DELIVERY OF PRESENTATION

Organization & Preparedness 1 2 3 4 5

Is well-prepared (does not reread article)
Handout is neat, organized, and logical

Presentation & Communication Skills 1 2 3 4 5

Proper rate and fluency of speech
Professional phraseology
Smooth delivery
Appropriate use of pauses

Scoring Key
1 = unacceptable
2 = poor
3 = acceptable or good (average)
4 = very good
5 = excellent or exceptional

FINAL SCORE (total/6):

REVIEWER COMMENTS:

Strength of Evidence by Study Design

Weaker		Stronger				
	Descriptive		Observational		Experimental	
Ideas, Opinions, Reviews	Case Report	Case Series	Case-Control	Cohort	Cross-Sectional	Randomized controlled trial
<i>*Systemic Reviews and Meta Analysis can apply to all study types*</i>						

- **Case-Control:** select participants by disease state
- **Cohort:** select participants by exposure then watch for disease occurrence
- **Cross Sectional:** select a population at a certain time point and study participant characteristics

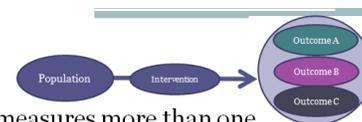
RCT - superiority vs. equivalence vs. non-inferiority

- **Superiority:** (most common) designed to detect a difference between the treatments
- **Equivalence:** designed to confirm the absence of a statistical (meaningful) difference in the treatments
 - What is defined in the study as a meaningful difference?
- **Non-inferiority:** designed to confirm that a treatment isn't worse than another (a standard of care or approved drug)
 - What is defined in the study as "not worse"?



RCT - Endpoints

- **Composite endpoints:** measures more than one outcome together as a group
 - **EXAMPLE:** cardiac death, non-fatal MI
 - Increases the number of events so a smaller sample size can be used
 - Generally considered a poor practice, as it "averages" the impact of all of the effects
- **Surrogate endpoints:** parameters that are thought to be associated with clinical outcomes
 - **EXAMPLE:** LDL reduction to predict cardiac death
 - Can't prove that the clinical outcome will occur
 - Can often allow a study to be shorter



RCT - Analysis

- **Subgroup analysis:** looking for a pattern in a subset of the study subjects
 - **EXAMPLE:** males and females
 - Best if planned ahead of time, instead of used as an added analysis of data later on in the study
 - Are usually unreliable and over-interpreted
 - Are often not properly powered (due to smaller sample size)
- **Intention-to-treat:** Analyzes outcome of **all** patients assigned to a treatment, even if they dropped out or were non-adherent with study drug administration
 - Advantage: better estimate of real world use
 - Disadvantage: may underestimate treatment effect
- **Per-protocol:** Only analyzes patient outcomes in those that adhered to the protocol
- **As-treated:** Subject outcomes are analyzed according to how they were treated
 - **EXAMPLE:** if a subject was assigned a treatment but did not take it they would be analyzed as if they were assigned to the placebo group

Measures of Magnitude of Association

- **Odds Ratio (OR):** Shows how strong having (or not having) a characteristic "A" is associated with having (or not having) characteristic "B"
 - Exaggerates changes and errors
 - Odds are generally greater than the probability
 - Can be close to the RR when the probability is very small
- **Relative Risk (Risk Ratio) (RR):** a ratio of the probability of having a characteristic "A" in an exposed group vs. an unexposed group
 - Considered easier to interpret and is preferred over the OR
 - Does not show frequency of event just that it occurs more often in one group compared to another

Both show the *direction* and *magnitude* of risk!

Drug Information Request and Response

Have your preceptor review your draft response. Only final versions are to be circulated.

Section 1 - General Information

1. Student: _____

2. Preceptor: _____

3. Date: _____

4. Initial information request (i.e., the initial question received):

5. Actual information needed/requested:

6. Category of request: Patient Specific (complete section 2)

not complete section 2)

Non-patient-specific drug information requests (do

not complete section 2)

Academic or educational information requests (do

7. Type of information requested (choose only one)

___ Adverse drug event

___ Formulary issue

___ Pharmaceutics (stability, etc.)

___ Alternative agent (e.g. herbal)

___ Foreign drug identification

___ Pharmacokinetics

___ Availability of drug

___ General information

___ Pregnancy/lactation

___ Dosage and administration

___ Identification of product

___ Therapeutics

___ Drug interaction

___ Investigational drug

___ Toxicology

___ Other _____

8. Method received:

___ telephone

___ rounds

___ hand written

___ email

___ other

9. Requestor information:

a. Name: _____

b. Affiliation/practice site name: _____

c. Telephone #: _____

d. Pager #: _____

e. E-mail address: _____

f. Fax #: _____

g. Background and practice site:

___ House staff physician

___ Hospital

___ Attending physician

___ Ambulatory care clinic

___ Nurse

___ Community/retail

___ Patient

___ Managed care organization

___ Family/Caregiver

___ Long-term care facility

___ Other background

___ Other practice site

Section 2 - Patient Data (if request related to specific patient)**1. Age:** ____**2. Sex:** ____M ____F**3. Weight (kg):** _____**4. Height (cm):** _____**5. Ethnicity:**

- ____ White
- ____ Black
- ____ Hispanic
- ____ American Indian
- ____ Asian
- ____ Foreign
- ____ Other (unknown)

6. List allergies/ADEs/intolerances:**7. Pertinent medical history:****8. Current problems/diagnoses:****9. Organ function:**

- a. Renal (CICr):
- b. Hepatic:
- c. Cardiac:

10. Medication history (medication, dose, dosage forms, route of administration, frequency, duration):**11. Pertinent laboratory values, other diagnostic test information:****12. Other pertinent information:**

Section 3 - Actual Question and Response**1. Drug information response:****2. Response provided to:** _____**3. Method response was provided:**

Face-to-face____ Phone____ Fax____ Email____ Mail____ Other____

4. Approximate time to answer question (minutes):

___< 5 ___6-15 ___16-30 ___31-60 ___61-119 ___120-239 ___≥ 240

5. Were copies of references provided to requestor? ___Yes ___No**6. References:**

List the sources and references (indicate primary or tertiary) used to formulate your response.

A minimum of two primary references must be cited. Note that drug information handbooks (print or electronic), PDA drug information programs, and class notes ARE NOT considered appropriate sources for the Drug Information Response. Electronic tertiary sources such as MICROMEDEX® may be used. Referencing format for books, journals and electronic media should be as discussed in PhPr 461c (*American Journal of Health-System Pharmacy* or *Uniformed Requirements* formats).

Extended Leave of Absence

VETERANS INTEGRATED SERVICE NETWORK 21

PHARMACY SERVICE RESIDENCY PROGRAMS

POLICIES AND PROCEDURES FOR RESIDENT REQUESTED EXTENDED LEAVE OF ABSENCE

July 2014

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Approved By:

1.0 Background

A Postgraduate Year One (PGY1) or Postgraduate Year Two (PGY2) Pharmacy Resident is offered a unique opportunity to be trained in a well-organized health care system, but is only given a temporary appointment at the facility. This temporary appointment does not allow the resident full access to certain leave policies (e.g., Family and Medical Leave Act). Nonetheless, a resident may find him/herself in a situation that requires that they request an extended period of time off. In the event that the Residency Program Director (RPD), Chief of Pharmacy or facility Human Resources service cannot utilize established policies or procedures to adequately accommodate a resident's request for extended leave, this policy and procedure has been established to provide guidance.

The RPD, Chief of Pharmacy, or Human Resources service is in no way obligated to exercise this policy and procedure. This policy and procedure does not supersede, negate or otherwise nullify any standing national, regional (e.g., VISN 21) or local policy regarding leave.

2.0 Policy

In the event that a resident requests an extended period of time off and is granted leave without pay (LWOP) to accommodate this request, the resident will have their temporary appointment extended beyond one year, in the amount of time necessary to complete their training (not to exceed three months). This extended amount of time is typically the same amount of time as the LWOP granted to the resident.

3.0 Definitions

3.0.1 Extended Leave Request

A leave request will be considered an extended leave request when the time off requested is for longer than 3 working days and not exceeding 3 months without adequate leave to cover it. Requests shorter than 3 working days that cannot be covered by accrued annual leave (AL), sick leave (SL) (if appropriate), or at the discretion of the Chief of Pharmacy, leave without pay (LWOP) are not considered significant enough to extend a residency beyond the scheduled one year appointment and will not be addressed in this policy & procedure. If an extended absence occurs (i.e. extended family or sick leave), extension of the residency program may be necessary. The maximum length of extension is not to exceed 3 months, and the program must be completed before September 30th. Opportunity to extend the program with pay will depend on the decision of the VA regarding extending the funding. It is recognized that a resident gains experience throughout the course of the year. If a resident is unable to return to the residency after 3 months, the resident is unable to build upon their experience gained prior to the leave. In this case, it is recommended that the resident voluntarily withdraw or resign from the residency.

4.0 Procedure

Trainees such as pharmacy residents who have legitimate reasons for extended leave can be placed on Leave Without Pay (LWOP) after using their accrued annual and sick leaves. It would be a rare occasion for a facility to grant advanced leave. Most facilities won't agree to put trainees in the Voluntary Leave Sharing Program but it has been approved for special circumstances. The resident who goes on LWOP may return to complete the program in a paid status for a time extension equal to the time of the LWOP. If additional time is needed beyond the extension to meet the training objectives that will not be met because of the extended absence on annual and sick leave, any additional time will be without pay. VA's Office of Academic Affiliations (OAA) will only pay for the equivalent of 12 months.

4.1 Resident requests leave

The resident must submit her/his leave request to the RPD in writing. If at all possible, the resident is encouraged to submit the request 2 months prior to requested time off. In the event of an emergent request, the resident should submit the request to the RPD as soon as possible. The written request should include:

- Dates requested off
- Reason for leave
- Amount of AL and SL accrued

4.2 RPD review of leave request

Upon receipt of resident's extended leave request, the RPD has to review the request for completeness.

4.2.1 RPD meets with resident to discuss request

RPD discusses request with resident, presents alternative options (e.g., use of AL, or SL) to accommodate request. Depending on length of requested leave, RPD may need to advise resident that they will be responsible to pay their share of benefits (portion that is normally deducted from paycheck), or risk losing benefits. (Government will typically continue to pay its portion of benefits, though facility's Fiscal department will have to be advised and a plan will have to be in place to secure this funding prior to leave being approved.)

4.2.2 RPD discusses request with Chief of Pharmacy

Based on written request and discussion with resident, RPD meets with Chief of Pharmacy to review request and potential ways to accommodate request. If RPD and Chief of Pharmacy refuse to accommodate request, RPD will present this decision to the resident and document decision in writing. If RPD and Chief of Pharmacy wish to determine accommodation to request using a LWOP and extending the residency, the RPD will contact the following sections to advise of situation and develop plan.

4.2.3 RPD contacts facility HR, Fiscal**4.2.4 RPD contacts VA PBM and OAA**

VA PBM Contact: Lori Golterman, Bill Jones

OAA Contact: Linda D. Johnson, Ph.D., R.N., Director, Associated Health Education

4.3 Based on guidance, RPD develops accommodation to leave request**4.3.1 Approval of accommodation by Chief of Pharmacy****4.4 RPD reviews approved accommodation with resident****4.4.1 RPD documents resident review and acceptance of approved accommodation****4.4.2 Approved accommodation not accepted by resident****4.5 RPD notifies Chief of Pharmacy, facility HR and Fiscal, VA PBM and OAA of accepted, approved accommodation****4.5.1 Notification of OAA**

If the extension goes into the next fiscal year (after September 30), the Office of Academic Affiliations (OAA) will send next fiscal year's funds to pay for the extension in the next year.

When a resident goes on LWOP, the program director should discuss this situation with the facility fiscal people to

- (1) tell them that the person is on LWOP but will be returning so fiscal won't send all of the unused money back to OAA ;
- (2) tell them the anticipated date of return so they'll know how much, if any, of the money should be returned to OAA that won't be used in the fiscal year; and
- (3) let them know that OAA will be sending additional funds in the next fiscal year to pay for the period of extension that goes into the next fiscal year.

The facility residency program director should let the Office of Academic Affiliations, Director of Associated Health Education know of the situation and how much funding, if any, will be needed in the next fiscal year to pay for the extension.

4.6 Resident goes on extended leave**4.7 Resident returns from extended leave**

VA Sierra Nevada Health Care System
Early Commitment Policy
January 2014

1. PURPOSE: To establish policy and procedures for early commitment to the postgraduate year 2 (PGY2) residency program in Psychiatric Pharmacy in advance of the matching process for VA Sierra Nevada Health Care System (VASNHCS), Pharmacy Service.

2. POLICY: VASNHCS may promote current VA postgraduate year 1 (PGY1) residents into a PGY2 residency in Psychiatric Pharmacy when general qualifications and selection criteria are met:

A. The PGY2 program and position are registered with the National Matching Service (NMS).

B. The PGY1 resident does not have to be registered for the Match (<https://natmatch.com/ashprmp/>) if accepting an early commitment to the PGY2 program.

C. The resident applicant must be a current PGY1 resident in a PGY1 VASNHCS residency program.

D. The PGY1 and PGY2 residencies must be continuous years of employment for the resident.

E. The PGY1 resident and PGY2 residency program director (RPD) must both sign a letter of agreement that commits the PGY2 position to the PGY1 resident. The letter of agreement is available at <https://natmatch.com/ashprmp/aboutecp.html>.

F. The PGY2 residency program will pay a fee of \$125 to the NMS for each position committed to the Early Commitment Process.

G. The letter of agreement signed by both parties and the fee must be received at NMS by the December deadline in the year before the residency begins.

3. RESPONSIBILITY:

A. The PGY2 residency program will be responsible for:

1. Registering the PGY2 program and position with the NMS prior to promoting or recruiting for the PGY2 program.

2. Recruit PGY1 residents
- B. Resident Applicant:
1. Must have satisfactory PGY1 evaluations
 2. Must be making progress sufficient to successfully complete PGY1 goals and objectives by June 30th of next year
 3. Demonstrate interest and motivation to do a Specialty Residency
 4. Prepare and delivery of a formal letter of interest to be considered for a PGY2 resident position.
 5. Adherence to all applicable deadlines listed above.
 - a. Return of signed offer letter is a formal written commitment by resident to the PGY2 program.
- C. Program Director:
1. Approve or deny early commitment.
 2. Prepare and deliver a formal offer letter for the PGY2 resident position.
 3. Adherence to all applicable deadlines listed above.
 4. Participation in ASHP PGY2 residency matching program according to all ASHP established guidelines and regulations.

4. PROCEDURE:

- A. The PGY1 resident will submit of a letter of interest or participate in an interview with the PGY2 residency program director.
- B. The letter/interview of interest must meet the following criteria:
1. Describe what the PGY1 resident would like to accomplish through the PGY2 residency
 2. Be delivered to the PGY2 residency program director and Director of the PGY1 residency by the first Friday in December at the latest (though preferred earlier).

C. If there are more than one PGY1 residents applying for one PGY2 position, the offering of the PGY2 position will be based on performance in the PGY1 position, formative evaluations, summative evaluations, and interview evaluations by the Resident Advisory Board (RAB) members.

D. Letters offering positions to selected applicants must be delivered in hardcopy format no later than the date of Early Commitment.

E. The signed offer letter must be returned to the PGY2 program director and copies given to the PGY1 program director.

5. APPEALS AND EXCEPTIONS TO THE POLICY:

A. No changes, modifications or exceptions to the policy will be honored without approval of the RAB.

B. All appeals must be submitted to the RAB in writing.