Brandon Jones:

Welcome, everyone. Hello and welcome to today's session, our edition of our monthly, it's actually been moved to more like a quarterly, pharmacy office hours. We're pleased to have you all here. On behalf of NACHC, I'm Brandon Jones, the director of health center operations and HR training within our training and technical assistance division. So we're excited to have you here.

Before we jump into our housekeeping and our content, I did want to hand things over quickly to my colleague here, Tim Mallett with 340Basics, who's going to give us a update on the 340B Grantees Conference. Tim?

Tim Mallett:

Great, thanks Brandon. Good afternoon everyone, and thank you for attending our session today. I just wanted to put out a reminder that the 340B Grantees Conference will be held the beginning of May in New Orleans. This is a grantees only conference. It doesn't have any hospital based to it like the coalition conferences, and so we feel that it's a very good introduction and update type conference because we're not getting pulled in different directions with the plenary and the other group meetings.

You will all get copies of these slides. The link at the bottom and the QR code will be active, and you can utilize that to get more information. It will be basically a two and a half day conference with topics really directly focused to what we're looking for as community health centers.

So pull it up. There is a initial agenda listed as well. One other real positive thing is that the New Orleans Jazz Festival is going on at the same time as our conference. So if you have time in the evenings, you may wander around town a little bit. Thanks Brandon. I will send this back to you.

Brandon Jones:

All right. Thanks Tim and look forward to that conference. Thanks for the update, Tim. All right, so before we get started, let me move our slide here. All right, so again, welcome. This is the Ins and Outs and the Dos and Do Nots of Residency Program Development with our speakers, Matthew Bertsch who's the director of education at Sun Life Health, as well as Kimberly Chen who's the director of pharmacy for North Country HealthCare.

All right. Before we get started, I have some housekeeping items to review with you. The duration of the session is approximately 60 minutes, including presentations and Q&A in the tail end. Please note again that this event is being recorded. If you're looking for the slides, they were emailed about an hour and a half ago, and we'll email them again once our session concludes.

The recording will be available within the week, the next week or so, and we'll post it on the Health Center Resource Clearinghouse as well as post it via [inaudible 00:02:59] if you're a part of that group. If you have any tech issues today, just feel free to send us a message in the chat and I will try to do our best to troubleshoot for you on those things.

And then I also encourage you to fill out our evaluation link that will be shared about five minutes prior to the end of today's session. You'll automatically be directed into it when the webinar ends. We'll appreciate your feedback to help us continue to improve these pharmacy office hours.

Also, if you have any questions or comments that come up during the webinar, we encourage you to engage with your peers and our presenters using the chat panel on the bottom right of your screen. If you have any issues with your audio, just recommend that you call in. There should be the call in information in your invitation as well, or you can click on the arrow next to the unmute button and switch to audio and you should be able to see the information there. All right.

Okay. All right. I'm going to hand things over to Matt Bertsch and get us started. Matt?

Matt Bertsch:

Well, good morning or good afternoon everybody, depending on where you are. My name is Matt. I am the director of education for Sun Life Health. We're an FQHC out here in Arizona. I'm going to run through the agenda real quick to start things off.

Today we're going to be talking about exactly what is a pharmacy residency program. We'll talk about why would your organization want to consider starting a residency program, how do you start a residency program? What are the accreditation requirements of a pharmacy residency program? What can a pharmacy resident do within your organization? How can you support or pay for a residency program? How does a pharmacy residency program benefit your organization? And lastly, advancing your health center by developing strong training programs. Next slide, please, Brandon.

Thank you. The first topic of conversation is what exactly is a pharmacy residency program? Well, it's really a postgraduate either year one or year two, usually one or both. You'll either be PGY1 or PGY2. And it's usually in a focused area such as institutional or hospital-based pharmacy, community-based or retail-based pharmacy or managed care. That's a PGY1.

When you look at PGY2s, they are focused even more on specialty, whether it's ambulatory care, more institutional psych, that sort of thing. That would be the second year of a residency program. And when we look at PGY1 or postgraduate year one residency programs, they really focus on three key areas. It's teaching, research, and clinical program development.

When we talk about residency programs in general, we look at programs, they're set up to really give the learner about three to five years of experience in a one-year timeframe. So residency programs are intense. They are a lot of work. Residents are going to put in more than that standard 40 hours a week. Like I said, they're supposed to be getting three to five years of experience in a one-year timeframe.

Now, the interesting thing about pharmacy residencies as opposed to residency programs in other fields is they're currently not required for licensure and practice as a pharmacist in any state, but they're often preferred by organizations when you're hiring into more advanced roles. So if an organization has an opening for a clinical pharmacist, they may want to see that residency experience on the applicant's CV or resume.

Kimberly Chen:

We're going to go to the next slide, Brandon. I'm sure many of you are wondering, well, why would we even want to consider a residency program? Isn't it just a lot of extra work for our staff and maybe the program director or if it's a dual role like me where you're doing pharmacy director and residency program director?

Well, there's three key areas that really are what you would want to start considering when you're starting to debate the do we do a residency program or not? The first is affordable staffing. Residents make about a third of a pharmacist's salary and they are a licensed pharmacist while they're on site. So you can use them for a certain portion of time as a staff pharmacist. So you're obviously getting staffing at a lower cost.

Once they are licensed, they do come in and they start in July 1. So often they're an intern for the first month or so while they pass their boards and get licensed in your state, but certainly offers affordable staffing.

The other thing is that residency programs are designed by the accrediting bodies to advance the progression of pharmacy in general. So the training programs are designed with standards that allow the organizations to improve their services and not remain stagnant.

That goes into this last point, which is develop clinical programs. Are you in a health center that is constantly considering should we start having a clinical pharmacist? How do we create more programs? How do we start to leverage getting that started without having more staff and really being able to make a strong financial argument to our C-suite about how to launch a new program?

Residents come with a fresh enthusiasm, they are excited to start programs, they want to be diving into patient care. So they bring energy toward developing those clinical programs. As I mentioned before, ASHP is driving that advancement of professional services and improvements at the professional level.

I kind of missed the point of my own bullet point there in the middle, but it's also you're advancing the profession by creating training programs. We'll talk a little bit later on about layered learning, but whenever you add training programs to your organization, you really are upping the game on your patient care because it adds that layer of constant learning to your organization. Next slide, please.

Matt Bertsch:

I want to kind of mentally think back to what Kim said in the previous slide. Kim was talking about some places might not know where to start. They might not know how to start clinical pharmacy programs. And by starting with the pharmacy residency program, that's how we started at Sun Life Health is we started our clinical programs with a pharmacy residency program. That might be a good way, a good financial justification for you to take to C-suite or senior leadership to say, "Hey, we might not be able to afford 10 clinical pharmacists right out the gate, but you might be able to afford a couple of pharmacy residents."

But you really have to think if you're ready for that accreditation. And approaching pharmacy residency accreditation is very similar to approaching accreditation kind of in any other field. Think about other accreditations or regulations that you have at your health center, whether you're joint commission accredited, think about your HRSA compliance manual, any other accreditation guidelines you have to meet. It's kind of the same way for pharmacy residency programs.

Now, the question can always come up, is it required to be accredited in order to have a residency program? That's probably a whole discussion in and of itself. But the short answer is no, you're not required to be accredited to have a residency program. But there are definitely perks. There are definitely advantages to being accredited, some of which we will definitely address later.

When we look at accreditation requirements, there're actually quite the lift. Now, much like joint commission or the HRSA compliance manual, it's an open book test. There are accreditation standards out there to follow, and it's kind of up to each organization how they're going to operationalize those accreditation standards. And I will definitely let Kim talk through some of those accreditation standards.

Kimberly Chen:

Yes, as Matt mentioned, the accreditation standards are a lift. The good news is, as you are probably familiar in the health center world, is that it is great to rely on each other. And so you're not starting from scratch. Many of us have gone before you and are willing to share what we've learned.

But because ASHP, if we're talking about accredited standards, uses this to drive the profession and advancement of the profession, standards really are encompassing of your entire organization and your department. This is one specific example I want you to start to think through. Pharmacy personnel practice at the maximum level of your state or jurisdiction. Actually the last words are blocked for me.

Examples of high level practice for their technicians, including tech-check-tech and immunizations, medication histories.

And so what does that mean? ASHP is essentially saying your staff need to be at the top level of their practice. How does that look in your organization? Are they there, or how would you be able to justify where you're at if they're not? We're going to look at three examples.

And then the second one is, all sites use pharmacists managed protocols and/or collaborative practice agreements, statewide protocols consistent with applicable laws and regulations. It's kind of an interesting thing which cart goes before the horse. You want to start clinical programs, but you're required to have collaborative practice agreements.

So how do you get there? The good news is if you start this process, you go through a process that we'll talk about here in the next few slides. You don't have to have it all out of the gate, but you have to be prepared to look at can we put protocols or collaborative practice agreements in place? Where is our organization in being on board with starting to leverage pharmacy in this way?

You cannot have a community-based pharmacy residency program that doesn't intend to have some type of clinical programs. You really can't run this a residency program just with dispensing services without partnering with other organizations or advancing the profession at your health center. So that's just something to keep in mind as we talk through these last points.

And then the last one is... Actually, I'm going to go back one more Brandon into that last point, that residents are licensed in the state. This seems like a simple standard to mention, but it is required by law, by accreditation standard, that they're licensed within 120 days of the start date.

Now, I don't know how many of you have hired new grads or what your state is like, but I can tell you that in Arizona every year, this deadline is a challenge. It is a challenge to get them through NABP process and then to get through the NAPLEX process. And so there are oftentimes, especially if a resident struggles with either law or the NAPLEX, that getting them licensed puts you at risk of having to terminate that resident.

I don't think this one is a deterrent, but it's absolutely, how are you going to address this? How are you going to structure a program that has them as an intern for the first 120 days? And then are you going to have flexibility to add time on at the end if they don't pass that? It's really just how do we want to approach it, but it isn't a little thing, and so we bring that one up as another example.

But there are a lot of standards, and they across all aspects of your organization. So Matt and I tried to kind of choose ones that showed what focused within the pharmacy team, but there are standards that talk about are you part of your organizational strategic initiatives? Is pharmacy involved in all aspects of your organization where a medication is? Clinic stock medications if you're in clinics that provide the medications for clinic administered medications, immunization. There's just lots of areas that the standards help to address, which can be really exciting if your organization's on board and you're trying to grow your programs.

But again, it does take thought and time. And I know on a later side we'll talk a little bit about, because I'm sure you're all thinking, well, okay, I may be interested, but how much time are we talking about? How much time does this take to put together and how much time does it take to maintain? We'll let Matt continue on with the next slide and delve more into that.

Matt Bertsch:

Just to kind of reiterate Kim's point, those were only three standards from two sections of the accreditation process. And there are many, many, many other standards that are out there, all of which

you have to figure out how you're going to operationalize. And then once you figure out how to operationalize it, you have to abide by it. That's what you will have your accreditation survey on.

But when we look at starting a residency program, we look at deciding on accreditation first. Like I said, you can choose whether to be accredited or not. Now, I would say the vast majority of people decide to go the accredited route. Why would that be? Well, I think one of the big things is you are privy to what is called the match. I think Kim goes into detail in a couple slides here as to what the match process is, what that looks like, exactly what the match is.

But much like medical programs have a match, pharmacy programs have a match as well. If you are not accredited, you are not privy to the match. That may be difficult to recruit candidates through other means or if you're unaccredited, might be difficult to recruit candidates in general because candidates want to see that stamp of approval that states that your organization has an accredited residency program.

After you've decided that, I would say most people would decide to be accredited, you want to review the standards and create a residency program manual. And so you'd review the standards which are published through ASHP, decide how you'll meet those standards and develop your operationalization of how to meet the standards. That's kind of the difficult part for a lot of people deciding how to operationalize those standards.

Then you'll go into the recruitment process to try to recruit residents. If you're accredited, applications are through a central source, it's all done through a system, much like pharmacy school applications are. It's very similar to that except these are residency program applications. They don't come directly to your organization if you're accredited, they come in through a central hub, a central portal called PhORCAS.

When you look at accreditation, if you're not accredited, you'll kind of recruit through your standard HR methods, but you'll also go to local showcases, regional showcases, maybe some national meetings and try to talk to some of the pharmacy students there who are P4s who are in their last professional year.

And then last but not least, you'll try to meet your requirements of accreditation, if you're accredited. The accreditation process is intensive. You'll have the accreditors come on site, they'll talk to you in depth about your program, they'll talk to your medical staff about the program. And you'll probably have to wind up developing new policies and procedures, and as we stated in the last couple slides, standing orders, collaborative practice agreements, things like that to show that you have a very strong clinical component to your residency program.

Kimberly Chen:

As Matt mentioned, why would you be accredited versus not? The match process is very much one of them. But the reason for that is we mentioned early on that many look at residency to hire clinical positions. So when we're hiring, many employers look at those who are in a residency program and look to see is the program accredited or not?

That's because the accreditation standards are so stretching of an organization that you kind of have an expectation of knowing what you should be able to expect from those graduates of an accredited residency program. Not to say that a non-accredited program can't do those things, but candidates often look toward those accredited programs because they see them as favorable in the job market. But the recruitment process and the match is definitely another benefit.

How does a match work? Well, a match process is designed to look at the prioritization of the candidate's interests and the program's interests. I'm going to describe that process, but I will tell you

that also on the website for ASHP, there's a cute little video that has moving pieces that can try to help design it.

It does work very, very similarly to a medical school matching process. As a matter of fact, the core programming is the same one used for medical match processes. It is required if you're part of an accredited program. The downside is you can't just interview and offer directly. So those of you who have students and have candidate students coming through, sometimes man, it would be nice to be like, "You are a great student, can you just be part of our residency program?" You are not allowed to do that. As a matter of fact, it is a very specific process and regulated and you are not allowed to even discuss how you're ranking candidates with them because we don't want to bias that program.

And so before you can start being part of the match, when you're in pre-candidate or candidate status, which is the first two phases, and that's why we told you you have time if you're going through accreditation, when you're in those candidate statuses, you do just use your regular HR processes. You can offer it to students that are coming through rotations and promote your program in that way.

This bullet point that says accreditation will be applied retroactively to those candidates, what the heck does that mean? What that means is once your program gets accredited, you'll then actually regenerate certificates of completion, and they will be able to claim that they were participating in an accredited program so they retroactively get the benefit of being part of a accreditation, whereas when they're graduating, their certificates will say from a pre-candidate or candidate program at the time of graduation.

So matching, what happens is you get applications that starts in November. Deadlines for all of those applications within the system, it's a platform called PhORCAS, are due by January 3rd, and that's actually a standardized date that's going into effect in this next residency cycle before programs had a little bit of flexibility. But the accrediting body has said that you cannot expect applications to be due any earlier than January 3rd. That is to allow candidates to have more time to go to showcase from ASHP and make selections and allow for them to utilize time off during schools usually in later December for time off to use that.

Then you go through an interview process, a selection and interview. That happens in January and February. You need to create rubrics on how you're going to select those candidates. You can do those interviews virtually or in person or a combination. That is up to the programs.

And then you rank candidates. What is ranking? Well, the programs look at all the candidates they interviewed, decide who they're going to rank, and then prioritize them at your top candidates, number one. You rank as many candidates as you're interested in.

Interviewing does not mean that you have to rank a candidate. There are times that you may interview and find red flags or see that there's absolutely reasons that that person should not be advanced. For example, our program does a clinical case as part of our application process and interview process, and if they don't get a certain score, then we deem that that's probably not going to be appropriate fit. And so we may not rank that candidate.

You rank and so does the candidate, so it is not totally on the program. And so the candidates then rank all of the programs that they interviewed with. And then this is where the system leans toward benefiting the candidate. Again, very complicated, but essentially if the candidate ranks your program as number one and you rank them as number one or lower, but they're your number one and you have it ranked with your top candidates, then you would match. You get that results mid-March. As a matter of fact, programs just matched March 15th, got their results.

And then if you don't match with your positions, there is a phase two. It works essentially the same except for instead of having about two months to go through the interview and rank process, you have

about two and a half weeks. Phase two allows for candidates who didn't match and then anyone who was interested in being part of residency but decided too late from a program or a candidate perspective can enter.

And then if you still don't match, there's a scramble. That is essentially getting a list of all the candidates who didn't match and proactively reaching out to them. This is obviously the least ideal because candidates have had multiple opportunities to select your program as being interested. And so at that point you're probably matching with a candidate who wants a residency but necessarily wasn't interested in your program.

It isn't as easy as just interviewing and offering a process. But the nice thing is during going through the accreditation process, you are required to create a very structured process to eliminate as much bias as possible. And so you're ranking the applications based on a rubric. You're doing interviews based on a rubric. It does allow team members in your organization to be actively engaged in that process.

You certainly would not rank any candidate that you don't think would be good for your organization, but it always does leave it open to who will we get. And so it's always an interesting day on match day to see what happens. You can go to the next slide, please.

Matt Bertsch:

Two things to go off of the matching process, and Kim's right, yesterday was match day, everybody excited to open their emails, candidates are opening their emails seeing what program they matched with because they don't know, all they know is who they ranked. So then the system gives you this response and then program directors are waking up at 4:30 in the morning scrolling through their email looking for the match email that says, "Congratulations, you've matched." You open the email and it tells you who you've matched with, if you've matched with, and then what your next steps are going to be.

And then also if you're an unaccredited program and candidates have gone through the match and have not matched with individuals, it's a perfect time to try to recruit some of those candidates into your own program if you're not accredited because just because they haven't matched doesn't mean that they're not qualified pharmacists at the end of the day. When we started our residency program here at Sun Life Health, we started with individuals who did not match, and they built our residency program from the ground up, which is awesome.

When we look at accreditation requirements of a residency program, what are the accreditation requirements? The current body for accreditation is ASHP, and for community based programs, it's co-accredited by APHA or the American Pharmacist Association. ASHP recently came up with a set of unified standards to make the standards across residency programs a little bit more unified between all of those programs. And like we talked about earlier, the standards cover everything from attendance time away from the program, because there is a maximum amount of time that the resident is allowed to spend away from the program, to requirements to pass residency. And there are a lot of requirements to meet.

When we look at programs in general, they're broken down into rotations. Your residents are going to be on various rotations. It's not like they're going to be doing the exact same thing every day for 365 days. These rotations can be rotational, which can be up to six week rotation. Sometimes it can be an administrative rotation or a focus on diabetes education or they can have continuous rotation, which is timeframe from six to 12 weeks.

They can have a longitudinal rotation which is greater than 12 weeks. So for a lot of us, the longitudinal rotation would be community pharmacy dispensing, things of that nature. There can be elective

rotations that are built in like weight management, pain management. Each residency program is going to look different. And there are customized plans for every residency program that's out there.

Kimberly Chen:

That's a great lead in to what your residents can do in your organization. When I first got into residency programs, I was not residency trained when I first came out of school, and so it was a little foreign to me. What I had in my mind was that all residencies were sort of like medical and what I knew in the hospital, which was you spent four weeks in med-surg and four weeks in ICU and four weeks on different floors. Many of the community-based residency programs, and I keep referencing that because most FQHCs would fall into that category, there is a saying amongst those of us who have residency programs that if you've seen one community-based residency program, you've seen one community-based residency program. That's because we vary so widely.

But those rotations are often divided by the topic as Matt referenced. So you might have an administrative and you might have a staffing component, but what those rotations allow you to do is to address areas in your organization as well. Our program is actually almost longitudinal in all of our rotations. What that means is they're doing all the rotations all year long. I share that so I can give you a frame of reference as we talk about what they can do in your organization.

My residents spend two days a week in am care, they spend one day a week in the pharmacy, they spend one day a week in anticoag clinic and they have a little bit of administrative time in the clinic. And so once they're licensed as a resident, they can do anything that a pharmacist can do.

Now, that does not mean that they're set loose and there's no additional lift on the organization. You still really need to be following the roles of a preceptor, so direct instruction, modeling, coaching, and then putting them to the facilitation model. But they can do whatever a pharmacist can do.

Obviously the quickest lift to allow them to independence in that facilitation role is working in the retail side as a staffing component. We actually build that in initially as a learning experience because we want to be able to be giving them feedback and evaluating them, but then they just become a staffing option.

But then they're also able to work on the clinical side. When we started our residency program at our organization, we had no clinical services just like Matt. And as the residency years went on, we've since launched an anticoagulation clinic, a transitions of care program, pharmacists embedded in the clinic in an ambulatory care setting. And residents can do all of that.

You need to be cautious if you're setting up privileging for your pharmacist that you don't privilege your pharmacist in a way that would exclude residents from being part of that, but it is very possible for them to serve as clinical pharmacists. Our residents, just like Matt's, sit in the pods with our providers and are there as a resource to them.

Now, there's another reference back to the accreditation standards here because you do have to remember to adhere to the guidelines. You can't just staff them all the time, and you have to make sure that the learner is constantly learning. They can't do things that your pharmacists aren't. So you can't just completely set them loose to launch a program independently.

And you need to make sure that they're balanced. They cannot spend 100% of their time in one disease state. There's actually accreditation standards that say they need to have a certain amount of time or certain percentage of their patient panel being in different disease states. They need to be able to give multiple types of immunizations.

There is some looking at the accreditation standards as you go through this, but it's very important to know that they can do all of those things that a pharmacist can do. They can start the programs. They

can't do it independently, but like I said, we've used them to launch our clinical services. They just need to be working alongside a pharmacist as a preceptor.

We also have them on committees. They like being engaged, they like being involved and having their opinions engaged. We have a layered learning model at our organization. We at North Country have a medical school on campus. We have a medical residency on campus, we have a pharmacy residency, a dental residency. And so they serve on our education committees to help grow our preceptor training and our preceptor appreciation and our geographical training model.

They serve on our workplace of choice, they serve on our P and T committee. So they have a lot to contribute and they need to be exposed and participating in those areas. So by putting them on those committees, you're also then helping to reach those accreditation standards but also lightening the lift of your team that's there.

So when we started out, again very small, I'm talking about a team of five pharmacists. So you can do it in a very small organization, but you certainly can't have those five pharmacists be staffing and doing all of these things to help broaden the organization to meet these requirements. And so residents are able to do that.

And then residents are really interested in being part of that layered learning model. So our residents precept pharmacy students and medical students and nurse practitioners, and they partner in a collaborative way with our medical residents. Instead of your pharmacist having to precept a resident and a pharmacy student and a medical student, you parse that out so that you're precepting the resident precepting others.

It really helps them to grow and lean in and then be able to step into organizations whether your own or others, where they're ready to know how to precept in a way that helps advance the profession.

Matt Bertsch:

Thank you, Kim. There is a question that's in the chat, and I don't mind kind of addressing the question. It's kind of a part of the alphabet soup that we have going on right now. The question is from Braxton, "Can we confirm that pre-candidate and candidate status programs do not go through the match? I was under the impression that all programs pre-candidate, candidate, and accredited programs are required to go through their residency matching program through ASHP. I want to clarify because I think it'll decrease the barrier burden for those thinking about new programs."

Now, part of the alphabet soup that maybe Kim and I didn't talk about was pre-candidate, candidate, and accredited. And then there's the, I haven't even walked down the road yet, which is the unaccredited side, means I have had no contact with ASHP, we're not doing the accreditation thing, and we're not going to even walk down that road. Whereas pre-candidate and candidate means that you're kind of in line for the accreditation process and you've kind of made that decision to become accredited. I do believe that pre-candidate and candidate are privy to the match. Is that correct, Kim?

Kimberly Chen:

You know Matt, with the standard exchange, I believe that's correct, but we may have to get back to you to double confirm that. But yes, I believe that is true.

Matt Bertsch:

Perfect. And thank you for that question. So, how can you support or pay for a residency program? This section is show me the money, because when you take this to C-suite, they're going to say, "Well, how are we going to afford that? How are we going to pay for it?"

Well, part of what your residents are going to be doing is expanding disease state management services with the pharmacy residents. You're going to be able to reach more eligible patients and provide more comprehensive services with your residency program. And there are some funding opportunities through health centers that we are able to use to put dollars towards programs which reach more eligible patients and provide more comprehensive services.

You can utilize your pharmacy residents as salespeople for your in-house pharmacy and try to increase your capture rate. Remember we always give patients the choice, but we always test our residents to see how well they can sell to the patients that they should use one of our in-house pharmacies. That brings more patient care in.

Support of dispensing services at dramatically reduced rate, staffing residents one day a week. It could actually be a cost savings measure because instead of having to hire an additional per diem pharmacist at X dollars per hour, you can hire a pharmacy resident and have them cover one day a week at a reduced cost.

Your pharmacy residents can develop new programs with lower paid pharmacist residents as a part of the requirements. These pharmacists, again, instead of hiring clinical pharmacists at X dollar per hour, you can utilize your residents to help fill that gap and create pilot programs to demonstrate value and the business case for sustained pharmacy services in new service areas. Again, this is a very low cost way to do this because again, pharmacy residents are probably about a third of the salary of a regular community or clinical pharmacist.

I think one of the other things that you can do in your organization is help close health plan gaps in care with the pharmacy residents, medication adherence, hemoglobin A1Cs that are being performed on your patients, things of that nature. Your pharmacy residents can kind of dive into a lot of different areas which could yield either direct or indirect revenue sources to the health center.

Kimberly Chen:

As we talk about the show me the money and we'll transition to the benefit of the organization, let me just answer a couple questions that I'm guessing are going to be coming our way, is that yes, they are a more affordable staffing. But there is sort of a cost that we haven't talked about that when you're precepting, that does reduce their ability to see patients. So it's not exactly always a one-to-one. You are getting the additional pharmacy staffing.

Most organizations will look at a full FTE pharmacist that's precepting a residency program and carve out a small amount of administrative time for the preceptor. That varies on how much time they're spending with the resident. If they're carrying on a resident for a full rotation, you might give them 0.1 during that time so they have time to do evaluations and things of that sort. If there's precepting in the dispensing model, there's probably not a change.

The other aspect to consider is that your residency program director by accreditation standard needs to at least have 0.3 FTE dedicated to the program. That time is needed. It varies in the beginning, and Matt will talk about this I think in a little bit, but how much time does the program director need to invest on the front end to get things up and running? And then how much does it take to sustain?

That is a cost consideration as well. But as you can see from Matt and I, it's just part of what we do in our roles. You don't need a full-time person to be a residency program director. It certainly can be part of what they do as staffing.

And so when we look at the benefits to your organization, obviously we continue to focus on the affordable staffing. It definitely helps. But I will tell you that when the pandemic hit, organizations with residents felt supported. It gave us more flexibility on how to cover these staffing shortages.

You couldn't just throw residents in staffing for eternity, but you certainly could rearrange their schedules and their way that they did things. And so it allowed us to be more flexible and nimble to provide critical services. This is true across all the types of residency programs.

I will tell you that while I don't know firsthand, I know the hospitals had to make more dramatic changes due to the utilization of the hospital beds, but even on the community-based side, we certainly were dramatically impacted. It also drove us to learn how to do services in new ways, leveraging telehealth in different ways and things like that.

As I mentioned earlier, it adds more pharmacists to your team. You do still need supervision there. But for example, we have two of our residents with one of our pharmacists in clinic right now. While she's not fully seeing 100% patients all the time, her residents are each seeing 100% patients all the time. So there is a synergy there that happens. It's not three full-time clinical pharmacists, but it's really like 2.8, and you're only paying for a much less reduced cost.

The innovative ideas is so important. The accreditation standards require actually that a resident launch or improve a new service every year. So you are constantly doing new product or enhancement of a current product. They're required to do a business plan, they're required to do a CQI project, and they are super enthusiastic. So if your team is feeling stale or stagnant or even just like they have ideas but don't have the capacity to roll them out, it gives you a way to take those ideas and put boots to the ground so you can actually move things forward and drive new innovation and programs and pilots.

As I mentioned earlier, it really creates better patient care. You cannot precept a resident and not be on your game. Well, I should back that up. You shouldn't be precepting a resident without staying on your game. And honestly, because of that passion that residents bring and the desire to learn and grow, it really infuses your whole team with that desire to be growing and learning and hopefully providing feedback in a positive way.

And so it opens up different dialogue even within your teams on how do we collaborate and how do we move from taking a new grad to a strong pharmacist? How do we take a resident into being part of the team outside of residency once we hire them on? And it causes growth across your team. Both Matt and I have used residents to then grow our programs by having the residents complete the residencies and then stay on in our organizations or go to other FQHCs and help them start these services because they're learning how to roll these programs out at our organization.

And then I think what I get most passionate about actually is this last bullet point. It encourages additional integrated models. You really can't continue to try to advance the profession without starting to talk about integrated care team models. Even if we're not talking about layered learning models or embracing all these other programs that you might hear Matt and I talk about, when you start to talk about clinical pharmacy services, you really are talking about working together with other healthcare professionals.

I will tell you that beyond a doubt, our pharmacy residency has changed the conversation of our organization on how we approach patient care and how we look at engaging in patient huddles and working with care managers and behavioral health, working with primary care and even other specialties. And then looking at specialty populations like HIV and hepatitis C.

We really are able to create a different dialogue and allow the organization to look at how do we approach integrating things a little bit better, breaking down those silos so pharmacy isn't about four walls, that pharmacy is about medication management and about integrating with helping every professional work for the top scope of their license.

It has really been a game changer for our organization and added such tremendous benefit to the types of programs that we're able to launch, the things that we're able to trial and sometimes fail fast. Not

everything that we launch is successful. And then there's times where we launch something and it is wildly successful and such a boon for your organization.

And so I can't speak enough to is the lift worth the outcome? Absolutely. I know that some of what we've talked about is, man, there's a lot of lift, but I can't tell you enough how much pharmacy residencies have benefited our organization and our community and honestly the community of health centers, because when we don't hire our resident afterwards, it's usually because they came from a different community and want to get back closer to home.

But so many of them land up in other health centers either in established programs or like I said, several of them have ended up at health centers where they've then helped to launch programs because they've seen that model, they've practiced it, they've been mentored in it, and so then they're ready to come into your institutions that may not have a residency program or have clinical programs and say, "Hey, I know how to get that started. I can do dispensing and then start to launch an anticoag clinic." And so there's just so many benefits.

And then I know Matt's going to start talking on this next slide if you want to advance it on how to talk about training programs because that's another passionate area for both of us. Matt, if you want to take it from here.

Matt Bertsch:

Absolutely. When we did a very quick analysis over what percentage of our pharmacy residents we retained as clinical pharmacy staff members, we're right at about 50%. So 50% of our graduates stay on board. Some of our graduates, as Kim alluded to, moved on to other health centers even in the state to go start, develop, bring up clinical pharmacy services in the state.

To go back to Braxton's question real quick, I did look at the match website and all PGY1, PGY2 pharmacy residencies that are ASHP accredited, are in candidate status or pre-candidate status must offer all positions through phase one of the match. So that is correct.

Now, candidate is an individual or is an organization that is a status that is granted to a program that has applied for accreditation and is awaiting the official site survey, and pre-candidate status is granted to a program that has indicated to ASHP that the program intends to apply for accreditation and wishes to participate in the match. And then like we talked about earlier, there's the, I'm not even going to walk down that road, and that would be the unaccredited standard.

We kind of wanted to wrap things up today by talking about advancing your health center by developing strong training programs. To do this, you kind of have to think about where your health center is at the current moment and where you want to be, because nationally there's a focus on developing strong training programs to advance training professions in our health centers.

Think about all of the areas that you need pipelines into in your organization, whether it's the medical side, which is part of the reason that we developed medical residencies. We've got nurse practitioner residencies that are coming about, dental residencies, but we don't want to lose the conversation about the importance of pharmacy residencies as well and the contributions that pharmacy residency can have to the organization.

Another topic to think about, is your organization a part of an area health education center or an AHEC? Now, the purpose of AHEC is to develop and enhance education and training networks within communities, academic institutions, and community-based organizations. In turn, these networks seek to increase diversity amongst health professionals, broaden the distribution of health workforce, enhance healthcare quality, and improve healthcare delivery to rural and underserved populations.

AHECs in your area, I would encourage everybody to see what your local AHEC is, and if you're not involved with an AHEC, to try to get involved with an AHEC.

The other thing is, do you have untapped partners in your community that you can really tap into to help develop strong training programs? Are there colleges of pharmacy in your neighborhood so that you can start being a precepting site or a rotation site for those pharmacy students? Do you have safety net hospitals that you could partner with? Are there really cool collaborative programs that you can develop with those safety net hospitals?

Other colleges or universities who do research and health equity or social determinants of health? Or do you have other FQHCs in your area that you could partner with for some of your pharmacy rotations? Much like we partner with other organizations to do our medical residencies, a lot of us have to collaborate with a local hospital. Well, why couldn't we collaborate with another organization for our pharmacy residency programs and really take the health center from a healthcare only environment to a teaching and learning environment?

That's what's really cool about pharmacy residencies is it just adds to the case to help continue to become a teaching health center and to become a strong training site and think about major teaching hospitals and how health centers could emulate some of those programs.

Kimberly Chen:

Matt, I'm going to interrupt you here. We do have a question in the chat that relates very well to what was just on that last slide, which is from Alana Scott. "How many clinical pharmacists do you think is necessary slash recommended to adequately precept a pharmacy residency program and also can physician serve as preceptors for pharmacy residents?"

I'll tell you that when our organization was in pre-candidate status, we had no clinical pharmacist. I believe that was true with Matt as well when we first started. We utilized our residency program to develop the clinical pharmacist role. But that's also why we have, do you have untapped partners in your communities? You do not have to have all of the rotations within your organization. So you could potentially start out partnering with do you have a rehab hospital to meet the transitions of care requirements or a kidney partner with a hospital to put some rotations there?

We didn't start out with a lot of residents. We started out with one resident. And so essentially by the time we were accredited, we had one clinical pharmacist and one resident and were able to move forward from there and grow the programs. Recently with the standard change, physicians or non pharmacists can serve as preceptors for residents, but you do need to have sort of a preceptor pharmacist counterpart for that learning experience.

Yes is the broad answer, but there are some sort of criteria about their qualifications and how they engage with providing feedback. But you certainly can do that. The caveat is that you kind of don't want to send your resident off with a physician or another practitioner and not have some pharmacist engagement and oversight because you want to make sure that they're engaging in your organization in the way that you want clinical pharmacists to be engaging.

So yes, they can precept. We actually have our residents sit in our medical residency office in the clinic and are precepted by a physician when they're precepting medical residents in an integrated model. So it certainly can happen, but there's also pharmacy precepting oversight to some extent to that as well. I don't know if you wanted to add to that question at all as well, Matt, on your program and how you started out.

Matt Bertsch:

Yeah. I actually support the use of non pharmacist preceptors like Kim does. I think it's important. Kim spoke very passionately and in depth about the integrated care models earlier, and I think it's important that we get out of this pharmacist silo and realize that we're part of a broader team out there. When you have pharmacy residents that do rotations with non pharmacist preceptors, they get kind of that outside of pharmacy box idea of things.

I want to wrap up the presentation, kind of a nice little bow, then I'll go back to the Q&A. We kind of talked about starting a pharmacy residency program and that it's a big decision. There are many benefits that the pharmacy residency program can bring to your organization.

And then maintenance of a pharmacy residency program takes work. Each year, you have to do a qualitative analysis on the program, look at your resident feedback, look at the preceptor feedback, change the program each year. You're consistently working on Plan-Do-Study-Act models to change the residency program process. Next slide, please.

That was the agenda that we wanted to talk about. I'll go back to the questions. There is a question by Christine. "How long on average did your ASHP accreditation process take?" Kim, did you have any feedback on that? Because that was a while ago and my brain is forgetting.

Kimberly Chen:

Well, mine was even longer ago than you, Matt, but I can say that it is a ongoing process. Our organization, once we declared pre-candidate status, it's about a year. We were able to walk it in three years. So pre-candidate status for a year, candidate status for a year, and then we had our onsite visit and were accredited by the third year.

Now, the accreditation process is not all or none. There's critical factors and less critical factors. They'll come on site for accreditation, and then you may be accredited for different lengths of time. Most new programs will get a shorter accreditation cycle, meaning in two years you might have to turn in a progress report and then be onsite evaluated in four years. Some programs get a one year.

I would not be intimidated on that because ASHP's design is not to say fail or pass. It's a weighted system so to speak. You definitely need to be making progress toward things, but their goal is to see more preceptors and programs happen because right now there's like 7,400 residency applicants I think was last year's number, somewhere around there. And there's only a couple thousand residency programs. So there is a need.

I will say when you narrow it down to community-based programs, which is what most health centers are, we're talking about less than 300 programs in the nation. And so you are needed if you are interested to create a program because it is so important.

I would say the lift is not yours to do alone. When Matt started, he worked with me and used a lot of our program manual. I worked with another program. So we work together because I wouldn't even say it's stealing shamelessly. We want to share shamelessly, we want to see other programs succeed and then partner together. It's kind of a collaborative on how to make our programs and our organizations better.

Matt Bertsch:

Right. To go off of that fact, Kim and I often will read a standard and we'll get back to each other and we'll throw text messages back and forth and compare to see how our programs do in these standards. So it's important that you find like-minded individuals that work near you to see how they're addressing some of their challenges as well and to have good peers.

Two questions are up here, one by Jennifer. "What does ASHP stand for?" The American Society for Health-System Pharmacists is ASHP. And Irma says, "I am a preceptor or tutor at the pharmacy school." I was not sure what that question was in reference to, but maybe it was in regards to our preceptors in general and what it means to be a preceptor. So just because an individual is a preceptor for a college of pharmacy doesn't mean that they're automatically going to be your residency program preceptor.

There is going to be a difference between those two designations, whereas the preceptor you will be probably associated to a college or to a university, whereas internally, there are certain preceptor requirements that have to be met for your organization as laid out in your residency program manual.

Kimberly Chen:

Yeah, I would just reiterate what Matt said is we talked about the accreditation standards. We didn't touch very much on the requirements to be a preceptor or a program director in an accredited program, but there are requirements around that as well. And so it is another way that it forces your organization to essentially be in that growing or growth mindset because you are preceptors and you as a program director need to be continually demonstrating and investing in the profession by presentations or being board certified. There's lots of requirements.

It looks like in the chat, "Is board certification required for pharmacy preceptors?" The answer is no and yes. There are lots of requirements, but there's lots of ways to meet those requirements. I am myself not board certified and qualify as a preceptor because of other means of getting there. Board certification is one way to meet some of the requirements, and it's certainly encouraged, especially on those preceptors that in the clinical settings. But again, absolutely not the starting point for that.

It looks like Matt is looking up the answer to Jennifer's question. Do you have that answer yet, Matt?

Matt Bertsch:

Yeah, I do. The website for ASHP is ashp.org, once again ashp.org. Looks like there's another question. "I'm hosting a resident right now, but I was approached by a residency program to be one of the sites for two days a week during a residency. I have enjoyed hosting, but would be my first step to transition from being a site as a part of an established resident to being an independent resident site?"

Now for me, I think that's a great idea because it allows you to dip your toes in the water without having to fully commit. You can go, "Okay, I can set up this rotation for this site. I can be two days a week for this site. Now what would it take for me to walk through the entire accreditation process and be responsible for this?" I think it's a great practice run. Kim?

Kimberly Chen:

Right. I think the question also, Matt, is what would be the next step? The next step would be, I would recommend going to ashp.org, pulling down those accreditation standards, and then having a conversation with your leader as to where is their aptitude for beginning to start to get these things together.

Again, being a site, there is a lot of benefit to being a site. You get the benefits of having the resident and it being a training and not having to carry the accreditation list. One of our largest CHCs in Arizona actually has a residency program, but they allow the university to be their partner, University of Arizona. And so they carry the weight of being the program director and all that administrative aspect.

So certainly if you think that your organization is big enough and ready for that lift, it's looking at those accreditation standards and starting to create a program manual. You may look at those standards and decide being a site works better for you at this time.

Brandon Jones:

All right guys, I'm actually going to jump on in here. Thanks again, Kim and Matt for some really great information here. I think questions are still probably going to roll in afterwards. Our attendees, look for a follow-up email that should be sending out as soon as we close the session with the evaluation link, which I have shared in here.

I've also shared some additional information in our chat around upcoming activities, particularly around our Cultivating Health Center Operations training. It's mostly administrative heavy, but take a look through there. There are some sessions that actually might be interesting to some of you all who are attending, so I would encourage you to look at those.

I also include the link to our archive recordings for all of our pharmacy office hours. In particular, I think what aligns very closely to this session is our three series that you may remember last summer-ish I think it was on the clinical pharmacy model. We had a three series integrated clinical pharmacy model series of office hours. So I encourage you to take a look at those if you haven't. It's really interesting and it aligns so well with today's content.

Thanks again to Kim. Thanks again to Matt and certainly Tim and Logan for your input in today's content. Enjoy your afternoon everyone.