old needles were better” and “the insulin pens are wasteful.”
Changing practice by eliminating vials and replacing them with prefilled pens, as with any change in practice, is an ongoing challenge. The continuous feedback and improvement made the transition to a new insulin administration system successful through the use of the PDSA cycle.


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Structure of postgraduate year 1 pharmacy residency interviews

In 2003, Mancuso and Paloucek1 conducted a survey of pharmacy practice residency programs accredited by the American Society of Health-System Pharmacists (ASHP) to assess the process used in evaluating residency candidates during interviews. Since this time, the number of ASHP-accredited residency programs has increased by over 60%. In addition, the granting of the bachelor of science in pharmacy degree was discontinued in favor of the doctor of pharmacy degree, and the pharmacy practice residency was converted to the postgraduate year 1 (PGY1) pharmacy residency.2-3 We conducted a study to determine if a standard exists among PGY1 residency programs regarding the interview process and to update the information provided by the Mancuso and Paloucek study.

A 37-question survey was created to gather information about the interview process at PGY1 pharmacy residency programs. The survey was posted online using a commercial Web-based survey tool. A link to the survey was e-mailed in November 2007 to the directors of all PGY1 programs listed with ASHP. This study received institutional review board approval.

Of the 544 programs that were sent a survey, 282 programs responded, resulting in a response rate of 52%. Many of these results were similar to those in the 2003 survey, including the types of application materials utilized, involvement of current residents, and overall interview structure. The differences are highlighted below.

First, over 90% of the programs asked candidates about time management. Time management was ranked the most important area of focus during the interview, while questions relating to extracurricular activities ranked least important. Approximately 50% of programs asked clinical questions, including questions about drugs of choice (35%) or guidelines (21%). Other methods used to assess clinical knowledge included asking candidates to give case presentations (14%) or prepare subjective-objective-assessment-plan (SOAP) notes for a case (9%).

Approximately 27% of programs required a presentation during the interview. The majority of the programs allotted 15–29 minutes for the presentations and required candidates to use slides.

Another trend, not mentioned previously, was requiring a photograph of the candidate as part of the interview process, required by approximately 17% of the programs. A quarter of these programs obtained the photograph before the interview, and the remainder took a picture during the interview.

A number of our results were similar to those of the 2003 survey and were not
Letters

included in this report. The goal was to provide new information to residency programs and pharmacy residency candidates. A higher percentage of programs responded to this survey than the 2003 survey, which may be attributed to the use of a Web-based survey tool.

Although some slight changes have occurred since 2003, many commonalities still exist among the PGY1 pharmacy residency programs concerning the residency interview process. However, there are also many differences. Overall, there is no one standard structure for the interview process.


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Unforeseen benefits of a managed care pharmacy residency program

Health Net, Inc. is a publicly traded health plan that provides benefits to approximately 6.7 million individuals across the country through group, individual, Medicare, Medicaid, TRICARE and Veterans Affairs programs. Our organization first considered a residency program in managed care to be a “value added” benefit to our department. We justified the position by stating that the resident’s obligations would be to assist in drug information requests and to support clinical programs. By having a residency program, we believed we would increase the pool of qualified candidates for our frequently vacant positions, and since many members of our staff were interested in teaching, we believed the residency program would contribute to one of our organization’s goals of being a great place to work.

Nontraditional health care settings must find resources internally to fund a residency program; thus, it was important to our organization that the resident directly contribute to the ongoing demands of our department.

In our program, the resident provides pharmaceutical care to our medication-therapy-management patients, reviews prior authorizations, writes and presents monographs and prior-authorization criteria for our pharmacy and therapeutics committee, conducts drug use evaluations, and develops a patient or provider outreach program to improve the quality of care that our members receive. In order to understand the impact of these activities, we believed it was important for the resident to gain experience in direct patient care, disease management, and the Healthcare Effectiveness Data and Information Set (HEDIS) measurement and reporting.

We reached out to a pharmacist employed by one of our contracted provider groups and asked if our resident could spend time in the pharmaceutical care clinic. The expected benefit of this relationship was to enable our resident to see the impact of our formulary decisions, plan restrictions, and clinical programs on the individual patient. The unforeseen benefit has been the relationship built between our organization and the provider group. The resident is the unofficial “backdoor” to the health plan, researching questions on prior authorizations, copayments, and formulary status.

Within our health plan, we reached out to the disease management department so the resident could gain experience on how we affect members telephonically, via the Internet, and through educational materials. The expected benefit was to ensure any outreach program developed by the resident and pharmacy department did not duplicate efforts in the disease management department. We designed our learning experience to encompass vendor relationships and outcomes reporting. The unforeseen benefit was the breakdown of silos and the active collaboration among our departments on improving patient care and prioritizing resources in concert.

Also within our organization, we developed a learning experience with the HEDIS team. The expected benefits of this were to ensure the resident understood the goals of the clinical pharmacy programs and understood how outcomes and success were measured. The

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