March 7, 2024

NOTICE

The Board of Directors of the Kaweah Delta Health Care District will meet in an open Academic Development Committee meeting at 4:00PM on Wednesday, March 13, 2024 in the Kaweah Health Medical Center – Support Services Building Copper Conference Room (2nd Floor) 520 West Mineral King Avenue.

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings (special meetings are posted 24 hours prior to meetings) in the Kaweah Health Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at Kaweah Health Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page https://www.kaweahhealth.org.

KAWEAH DELTA HEALTH CARE DISTRICT
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Board Clerk, Executive Assistant to CEO

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400 West Mineral King Avenue · Visalia, CA · (559) 624 2000 · www.kaweahdelta.org
OPEN MEETING – 4:00PM

CALL TO ORDER – Ambar Rodriguez

Public/Medical Staff participation – Members of the public may comment on agenda items before action is taken and after it is discussed by the Board. Each speaker will be allowed five minutes. Members of the public wishing to address the Board concerning items not on the agenda and within the jurisdictions of the Board are requested to identify themselves at this time. For those who are unable to attend the beginning of the Board meeting during the public participation segment but would like to address the Board, please contact the Board Clerk (Kelsie Davis 559-624-2330) or kedavis@kaweahhealth.org to make arrangements to address the Board.

1. **CLINICAL EDUCATION** – Presentation of the Nursing Preceptor Program at Kaweah Health.
   Mara Lawson, RN, Director of Clinical Education, Nursing Professional Development Practitioner

2. **PHARMACY RESIDENCY PROGRAM ANNUAL PROGRAM REVIEW** - Nicole Gann, Inpatient Pharmacy Clinical Manager & Cory Nelson, Ambulatory Pharmacy Manager

ADJOURN – Ambar Rodriguez

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.
Mission and Purpose: The Academic Development Committee of the Board serves to strengthen our institutional pillar of empowering through education. Kaweah is a teaching health care organization and education is the foundation that enables Kaweah's teams to provide world-class care to our community in a constantly evolving medical climate. Members provide strategic guidance and support for the development and enduring success of our educational programs.

Specific Responsibilities: Review of GMEC oversight of GME including the Annual Institutional Review and annual program evaluations for all residency programs. Provide oversight of Annual American Society of Health System Pharmacists program reviews. Annual budget review and feasibility assessments for new & expanding programs. Collaborate with the Human Resources department and help with enterprise strategies for the education of our workforce. Monitor program retention and attrition along with compliance with ACGME, ABMS, CMS, ASHP and the Joint Commission. This committee will also serve to foster educational alignment with institutional goals and metrics.

3.13.24 Agenda:

Clinical Education - Presentation of Nursing Preceptor Program at Kaweah Health – Mara Lawson, RN, Director of Clinical Education, Nursing Professional Development Practitioner

Pharmacy Residency Program Annual Program Review – Nicole Gann, Inpatient Pharmacy Clinical Manager & Cory Nelson, Ambulatory Pharmacy Manager
Team Nursing Model

Clinical Education’s Role
Background

• Industry moved away from LVNs in acute care
• Nursing shortage since early 2000s compounded by COVID pandemic
• RN contract labor costs not sustainable
• Nurse to patient ratio impacts patient care
Challenges

- Staff memory of why we went away from LVNs
- Unaware of what LVNs learn in school
- Lack of trust – “It’s my license”
- Current workforce consists of many new nurses
- LVNs changing from SNF to Acute Care mindset
- Change Fatigue!
Our Process

RESEARCH

• *Outside the Walls* –
  • What are other organizations doing?
  • Locally & nationwide

• Scope of practice –
  • Consulted BRN & BVNPT
  • Internal scope – more restrictive

• Input from front line nurses
  • Things to consider

• Workflows for all units

• Failure Mode Effect Analysis (FMEA)
Our Process

CREATE

- **New model**: 1 RN + 1 LVN = Team Nursing
- Standardize orientation checklists (RN & LVN)
- Delegation Guidelines document (Yes/No)
- Nursing workflows
- Classes for RNs & LVNs – Director support
- Kaweah Compass page to house resources
Our Process

CREATE

Team Nursing Class

Agenda

• Why We're Here
• Orientation Plan
• Scope of Practice
• Delegation
• Workflow
• Patient Care Scenarios
Our Process

CHANGE

• Orientation for existing break relief LVNs
  • Additional training for skills they didn’t receive (central lines, handoff report, etc.)

• Sustainability:
  • Adding team nursing training to orientation plans for new nurses
  • Policies & resources – RN to Licensed Nurse
    • RN only items
  • Registered Nurse Residency Program → Licensed Nurse Residency Program
Our Process

EVALUATE

• Team Nursing taskforce
  • Dashboard items
• Survey nurses on team nursing units
• Trialing different models
Strengths

- Input from bedside nurses
- Utilizing full scope for LVNs
- Team nursing resources added to Kaweah Compass
- Partnership of unit leaders & clinical educators
- Education for existing nurses and new hires
- Expanded Nurse Residency Program
- Increased LVN pay to compensate for increased responsibility
- LVNs motivated to go back to school to become RNs because of team nursing
Weaknesses

• TIME - removed a lot of educators from normal duties
• Not fully staffed for LVN or RN positions
• Not popular model amongst nurses
Opportunities

• Expand Preceptor Class to include LVNs
• Expand Clinical Education to include LVN
• Change culture of our workforce to be supportive of team nursing
Threats

- Recruiting RNs & LVNs into team nursing model
- Retention of current staff
- LVNs not respected by some staff for their scope of practice & abilities
- LVN perception of doing the same work as RNs for less pay
- High patient acuities and high census makes this model challenging
Live with passion.

Health is our passion. Excellence is our focus. Compassion is our promise.
Pharmacy Residency Programs

PGY1 Pharmacy Practice and PGY2 Ambulatory Care
March 2024
Objectives

• Understand pharmacy training pathway
• Understand pharmacy residency accreditation
• Review Kaweah Health Pharmacy Residencies
• Assess current and future state of each pharmacy residency program
• Review value of pharmacy residencies to organization
Pharmacist Education

Pre-pharmacy Training
- 2-4 years of focused undergraduate training
- Majority have BS degree

Doctor of Pharmacy
- 3-4 year curriculum
- 1 year of non-didactic rotations

Pharmacy Residency
- 1-2 years
- Requirement of clinical pharmacist positions

Board Certification indicates advanced level of practice

In 2023 4,099 of 12,449 Pharm.D. graduates entered into a residency

Residency Accreditation
- Programs are evaluated based on set Standards
- Includes pre-visit work and a site visit from accreditors
- Accreditation is granted for 1-8 years

20/41
Pharmacy Residency

PGY1 Pharmacy Practice Residency
• One-year residency programs designed to develop clinical pharmacists responsible for medication-related care of patients with a wide-range of conditions
• Graduates are eligible for board certification and for PGY2 pharmacy residency training

PGY2 Residency Programs
• One-year residency program designed to build upon PGY1 while focusing in a particular area of practice
• Examples Include: Ambulatory Care, Critical Care, Emergency Medicine, Infectious Disease, Oncology, Pain and Palliative Care, Administration
Pharmacy Residency

Match Trends

2023:
6,019 Candidates competing for 5,256 Positions Nationwide

Note: Excludes positions filled in the Early Commitment Process.
PGY1 Pharmacy Practice

Program Overview

- 2 Pharmacy Residents
  - Evidenced based practice
  - Practice leadership

- ASHP Accreditation Granted
  - October 2023
  - Pending final accreditation length

- Program Graduation Requires
  - Staffing Requirement
    - ✓ (340 hours per resident)
  - Research/Quality Improvement Project
  - Teaching Certificate Program
  - Formulary Projects
Program Structure

Hospital & Department Orientation (3 weeks)

Core Rotations:
- Ambulatory Care (4 weeks)
- Pharmacy Practice Management (4 weeks)
- Infectious Diseases (4 weeks)
- Internal Medicine 1 (4 weeks)
- Internal Medicine 2 (weeks)
- Critical Care (4 weeks)
- Pain Management (4 weeks)
- Emergency Medicine (4 weeks)

Longitudinal Experiences:
- Medical Emergency Response
- Formulary Management
- Residency Project
- Staffing
- Teaching Certificate Program
Program Structure

**Project Work**
- 2 half days per rotation
- Month of December
  - Includes ASHP Mid-year, Project Days, PTO

**Electives (3 x 4 weeks)**
- Anemia Management
- Advanced Pain
- Anticoagulation (inpatient)
- Critical Care II
- Drug Information
- Emergency Medicine II
- Informatics
- Pediatrics/NICU
null
- Strong clinical acute care experiences in a variety of settings
- Talented and experienced preceptors
- Improves employee satisfaction & provides professional development
- Partnerships with UCSF strengthens resident experience

- Team rounding limited to certain patient care units
- Difficulty recruiting and retaining to rural area

- KH has extensive medical residency programs to further integrate training
- Almost 65% KH retention rate of residents after completion of residency

- Current economic climate has caused a decrease in resident applicant pool (ultimately impacts clinical pharmacist recruitment)
- Decreased # of inpatient jobs after residency completed

PGY1
Ambulatory Care PGY2

- First PGY2 program in the Central Valley
  - 2018-2019 Residency Year

- ASHP Accreditation Granted
  - July 2, 2018
  - Anticipated next accreditation: May

- Early Commitment option for PGY1s interested in PGY2

- Program Graduation Requires
  - Research Project
  - Business Plan for a Pharmacy Service Line
  - Staffing Hours – coverage of pharmacist shifts
PGY2

- Required Block Rotations (4 d/w):
  - Family Medicine (8 weeks)
  - Specialty Clinic (8 weeks)
  - Rural Health Clinic (8 weeks)

- Required Block Rotations (2 d/w):
  - Pain Management I (12 weeks)
  - Primary Care (12 weeks)
**PGY2**

- **Required Longitudinal:**
  - Staffing (1/2 day per week)
  - Practice Management and Leadership
  - Scholarship and Teaching

- **Elective Rotations (2 d/w):**
  - Pain Management II
  - Cardiology
  - Nephrology
  - Endocrinology
  - Will explore other options based on resident interest
- Strong clinical patient interactions/responsibility
- Talented and well-trained preceptor team
- Variety of practice settings
- Partnerships with UCSF and UMN to strengthen resident experience

- Limited elective experiences, especially in specialty areas (MH, ID)
- Moderate interaction with medical residents
- Difficulty recruiting to rural area

- KH has extensive medical residency programs to further integrate training
- Key Medical Group as potential partners in training
- Could seek partnership with Fresno areas to provide elective opportunities

- Kern Medical Center started a PGY2 in Ambulatory Care in 2022
- PGY1 programs with a strong ambulatory care focus
Why?

Benefits to the Organization

- External Funding (PGY1)
- Education and Scholarship
- Patient Care Quality & Compliance
- Pharmacist Recruitment & Development
- Cost Reduction & Service Growth
Pharmacy Resident Value Added

To the Organization and Community

- **Supports Patient Care**
  - Expands the reach of the current clinical pharmacist as resident can:
    - Attend Code Blues and RRTs
    - Makes recommendations to improve medication therapy
    - Complete consults, therapeutic interchanges and automatic adjustment
    - Expands outpatient clinic volume

- **Improves the Quality of Health Care Services**
  - Completion of residency related quality improvement and/or research projects
    - Example Projects: Implementation of long-acting antipsychotic service line, review of clinical outcomes of pharmacist-managed type-2 diabetes mellitus, Implementation of Cerner smart template to improve consult workflow, Impact of ED RPh interventions on use of LMWH over UFH

- **Supports Medical, Nursing and Patient Satisfaction**
  - Resource for medication information and medication therapy optimization
  - Participate in patient counseling or medication history review
  - Provide educational in-services
  - Reduction in complex visits for primary care providers
  - Improved patient care experience for patients with multiple chronic conditions/medications

- **Cost Reduction**
  - Reduce pharmacist recruitment costs by retaining current residents into open pharmacist positions
  - Residents cover inpatient pharmacist shifts on the weekends (680 hours/year) and ½ day per week outpatient (208 hours/year)

- **Professional Development, Education and Scholarship**
  - Provides for development of leadership/clinical skills of current pharmacist staff through precepting
  - Allows current pharmacist staff to contribute to research and/or quality improvement projects w/ opportunity for publications
  - Journal Club and Topic/Case Presentations for continuing education to current pharmacist staff
Example Resident Research
The Impact of Emergency Department Pharmacist Interventions on the Use of Low Molecular Weight Heparin over Unfractionated Heparin to Reduce Medication Error Rates

Jeevan An, PharmD, Kathryn Smith, PharmD, BCPS, Savannah Frady Lail, PharmD, BCPS, DCCC, Christopher Mahaffey, PharmD, BCPS, Kaweah Health Medical Center, Visalia, CA

Background

- Unfractionated heparin (UFH) infusion and low molecular weight heparin (LMWH) are guideline recommended and FDA approved for acute coronary syndrome (ACS) or venous thromboembolism (VTE) treatment
- UFH infusions are prescribed more frequently compared to LMWH despite unfavorable characteristics that can lead to adverse outcomes and errors:
  - ↑ risk of heparin induced thrombocytopenia
  - Close monitoring of partial thromboplastin time (PIT)
  - Narrow therapeutic range
- LMWH has lower medication error risk, and with the added ease of administration, may be initiated quicker in select patients with ACS or VTE
- Pharmacists’ role to decrease error rates was implemented by recommending a LMWH whenever appropriate in patients with ACS or VTE

Methods

- DESIGN: Retrospective, quality improvement, medication use evaluation (MUE)
- INCLUSION CRITERIA:
  - Adult patients 18 years or older presenting to the ED from November 1, 2020 to September 30, 2021
  - Confirmed diagnosis of ACS or VTE
  - ACS defined as unstable angina, non-ST-elevation myocardial infarction, ST-elevation myocardial infarction
  - VTE defined as pulmonary embolism or deep vein thrombosis
- EXCLUSION CRITERIA:
  - Patients admitted for non-ACS or VTE related problems
  - Vulnerable patient populations such as children, pregnant women, and prisoners

Primary Outcome Data Collection:
- Total number of pharmacy interventions made that switched UFH infusion to LMWH

Secondary Outcome Data Collection:
- Age, sex, weight, initial coagulation lab markers, initial indication, anticoagulation medication prescribed, baseline creatinine clearance (CCr), history of ACS or VTE
- Hemodynamic status on admission, time to initiation of anticoagulation

MUE/HIPAA Data Collection:
- Diagnosis, unit location, weight used to calculate heparin dose
- Review MUE data reporting system for known errors
- Medication errors to be identified with heparin infusions:
  - Incorrect weight programmed and used to calculate initial bolus and maintenance dose
  - Incorrect initial heparin bolus dose given
  - Not ordering PIT levels at the correct time or levels not drawn on time
  - Inappropriate adjustment of heparin infusion rates
  - Not administering the needed heparin boluses

UFH to LMWH Switch Criteria

Switch Criteria to Switch to LMWH
1. End stage renal disease (CCr <30 mL/min or on renal replacement therapy
2. VTE weight 15 kg
3. Hemodynamically unstable (SBP ≤90 mmHg or RR ≤12 or ≥24)
4. Cardiac mechanical anticoagulants prior to admission

Research Purpose and Outcomes

- Purpose:
  - To quantify the ED pharmacist’s interventions regarding the choice of initial parenteral anticoagulant and assess opportunities for optimization of prescribing practices for patients with ACS or VTE
  - Primary Outcome:
    - The number of medication errors potentially prevented by the ED pharmacist team by recommending a switch from UFH infusion to LMWH in select ACS or VTE patients
  - Secondary Outcomes:
    - Number of UFH infusions ordered for patients that met the criteria to switch to a LMWH that could have been intervened on
    - Difference in time to initiation of anticoagulation

References

Author of this presentation wants to have the following discussion:


Disclosures

Author of this presentation has the following disclosures:

- Being consulted to disclose
- Speaking in relation to disclosure
- Consulting for disclosure
- Ownership in related company

Results/Conclusions

In progress
Implementation of a Cerner Smart Template Powerform to Improve Pharmacist Consult Workflow

Ryan Rana, PharmD, Steven Richardson, PharmD, BCIDP, AAHIVP, Nicole Gane, PharmD, BCPS, Blake Bartlett, PharmD, Kelvin Tran, PharmD
Kaweah Health Medical Center, Visalia, CA

Background

• At Kaweah Health, the value of pharmacist participation in the vancomycin consult service is apparent, however, the current consult workflow process, as mapped in Figure 1, could benefit from optimization.
• There are many redundant steps in the current documentation process and the data mining in order to complete the vancomycin workflow is time consuming.
• The goal of this project is to analyze current workflow and then redesign and implement a new workflow to support completion of vancomycin consults utilizing new Smart Template functionlity within the EHR thus eliminating unnecessary steps and streamlining workflow.
• Improvement of workflow could be beneficial in optimizing the efficiency of the daily activities performed by the clinical pharmacists, potentially capturing additional time in the pharmacist day for focused effort on other essential clinical pharmacist activities.
• The results of this study could show the benefit of implementing a new Powerform into the pharmacists’ workflow and could lead to further improvement of the EHR system to provide pharmacists time to focus on other clinical aspects of their job.

Objectives

• Purpose: Improve the efficiency of current pharmacist workflow for vancomycin consult management
• Objectives: Primary: Reduce redundancy in the documentation process and decrease manual data mining of clinical patient information measured by time to complete a vancomycin consult. Secondary: Increase pharmacist work satisfaction with the vancomycin consult service.

Acknowledgements

• The primary research team would like to thank the individuals and institutions involved with this pharmacy research opportunity from Kaweah Health Medical Center.
• The primary study investigators have no relevant financial or nonfinancial relationships to disclose. All images are from copyright approved for commercial use.
• Contact Information: Ryan Rana (rana@kawaihealth.org)

Study Design

• This quality improvement project will involve implementation of a new Powerform with Smart Template functionality within the EHR system aimed to improve and streamline the pharmacist workflow process.
• Pre- and post-implementation measurements of the time to complete a vancomycin consult as well as differences in work satisfaction of the pharmacist will be measured and reported as part of the implementation process.
• Primary objective:
• Data collection of the time to complete a consult will be accomplished using completed pharmacist intervention forms on the EHR during a two-week window both before and after implementation of the new form template.
• Pre-implementation data will be pulled using an existing KD Hub (discrim Report while post-implementation data will be pulled from a new KD Hub Discrim Report compatible with the new Powerform.
• Data points to be collected include the following data: type of consult, time started, time completed, estimated time to complete, patient flow, pharmacist shift, and pharmacist name.
• Secondary objective:
• Data collection for work satisfaction will be accomplished using an electronic survey tool and emailed pre and post implementation of the new workflow to all pharmacists participating in the vancomycin consult workflow and the difference in scores will be reported as an outcome measure of the intervention.

Results

• Initial facilitation meeting to determine new workflow has been completed.
• Pre-implementation surveys will be sent out in December. Powerform implementation will go live in the new year with post-implementation surveys to follow.

References

2. Rana RR, Richardson S, Gane N, Bartlett B, Tran K. A pilot study of a Cerner Smart Template Powerform and its impact on vancomycin consult workflow. Presented at the American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting; December 2020; Las Vegas, NV.
4. Rana RR, Richardson S, Gane N, Bartlett B, Tran K. The impact of a Cerner Smart Template Powerform on vancomycin consult workflow. Presented at the American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting; December 2020; Las Vegas, NV.
5. Rana RR, Richardson S, Gane N, Bartlett B, Tran K. A pilot study of a Cerner Smart Template Powerform and its impact on vancomycin consult workflow. Presented at the American Society of Health-System Pharmacists (ASHP) Midyear Clinical Meeting; December 2020; Las Vegas, NV.
Implementation of a Standardized Inpatient Electronic Health Record Based Oral Chemotherapy Monitoring Process to Improve Pharmacist Workflow
Elysia Lee PharmD, Mara Miller PharmD, BCPS, Brooke Sabella PharmD, Eva Coulson PharmD, BCPS, Rheta Silvas PharmD, Blake Bartlett PharmD
Kaweah Health Medical Center, Visalia, CA

Background

- The utilization of oral chemotherapy (OC) agents has been increasing due to increased market availability of oral agents as well as ease of administration and convenience for the patient.
- A majority of OC medications utilized at Kaweah Health Medical Center are non-formulary agents.
- Institutional guidance at Kaweah Health Medical Center defines the necessity of pharmacist involvement in OC monitoring.
- Current policy defines specific agents that require review by two chemotherapy competent nurses and a clinical pharmacist. For agents not specifically listed in the policy, a chemotherapy competent nurse or pharmacist should perform a review to determine if the agent warrants additional review.
- The current procedure for documentation of initial review and monitoring of OC can be optimized.
- Kaweah Health Medical Center has developed PowerForm templates within the electronic health record (EHR) as a means to document assessments, monitoring and interventions for other select medications.

Objectives

- Improve efficiency of pharmacist assessment and documentation for ongoing monitoring of OC medications
- Increase pharmacist work satisfaction through the implementation of a new workflow
- Increase pharmacist compliance with documentation of initial review and ongoing OC monitoring

Study Methods

- Single center quality improvement project

  Outcomes
  - Time to complete OC monitoring
  - Pharmacist satisfaction with the workflow
  - Overall compliance rate of OC precaution order comments and documentation of OC monitoring

  Data Analysis
  - Data collection for time requirement and pharmacist satisfaction will be collected using an electronic survey tool and emailed pre-and post-implementation of the new workflow to all pharmacists participating in the OC monitoring.
  - Data collection for the overall compliance with OC precaution order comments and documentation of OC monitoring will be collected via chart review for a 3 month period pre-and post-implementation of the new workflow.
  - Results will be analyzed using descriptive statistics.

Research Timeline

- Pre-implementation survey sent out in November 2022.
- PowerForm implementation due to be determined.
- Post-implementation surveys will be completed post-implementation of new monitoring workflow.

Disclosures

- The primary study investigators have no relevant financial or nonfinancial relationships to disclose.
- Primary contact information: Elysia Lee (elysia@kaweahhealth.org)

References

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*Resident retained into KH PGY2 Program
Pharmacist Retention, Development and Satisfaction

- Inpatient Clinical Pharmacists (50 pharmacists)
  - >78% of Pharmacists have completed PGY1 residency
  - 22% of Pharmacist have completed PGY2 residency or Fellowship training in specialty areas
  - >45% of Pharmacists have obtained BCPS or related certification

- Ambulatory Care Pharmacists (6 pharmacists)
  - 5/6 pharmacist have completed 2 years of post-graduate training
  - 3/6 (3/4 eligible*) board certified (BCACP, BCPS, BCGP, BCPP)

  - Highly skilled pharmacists look for job opportunities that include residency programs
  - Residency Programs promotes workplace energy, practice reflection, innovation and enhanced focus on quality improvement
  - Resident Projects enhance workplace experience
  - Retention of current resident offsets recruitment, orientation and training costs
Contact

Nicole Gann, PharmD, BCPS
Inpatient Pharmacy Clinical Manager
PGY1 Residency Program Director
T: 559-624-5922  F: 559-713-2306
ngann@kaweahhealth.org

Cory Nelson, PharmD, BCACP
Ambulatory Pharmacy Manager
PGY2 Residency Program Director
T: 559-624-6916  F: 559-735-3061
conelson@kaweahhealth.org
Live with passion. Health is our passion. Excellence is our focus. Compassion is our promise.