

BOARD OF PHARMACEUTICAL SPECIALTIES
OPEN HEARING ON A NEW SPECIALTY IN AMBULATORY
CARE PHARMACY PRACTICE, DECEMBER 9, 2008-ORLANDO, FL.

Jannet Carmichael: If I could to ask everyone to take their seats, we'll get started. For those of you who think you might have wandered into the wrong room, this is the Board of Pharmaceutical Specialties open hearing on the petition, which we've just received for the new specialty in Ambulatory Care Pharmacy Practice. So that's what we're going to be talking about for the next couple of hours.

My name is Jan Carmichael. I am the current Chair of BPS and this is our first open hearing on a new petition which we've just received. As you probably all know, BPS has been responsible for the specialty recognition of Pharmacy Specialties and Certification of those specialties for more than 30 years. This is an open hearing where the profession can advise BPS about the pending petition for a new Specialty in Ambulatory Care Pharmacy Practice.

For those of you who haven't been around quite this long, BPS was established in 1976 by APhA. Prior to that time, probably in the early 70's, changes occurred in healthcare and pharmacy practice that indicated a need to officially recognize some pharmacy groups or areas of practice and focus of knowledge and expertise, as pharmacy specialties. In January of '73 APhA created a Task Force on Specialties in Pharmacy to consider the issue of Specialization in Pharmacy Practice.

BPS was officially established in 1976 with Nuclear Pharmacy as the first identified specialty in 1978. At the end of our testing year this year there were about 8,000 Board Certified Specialists in Pharmacy. The mission of BPS was recently redeveloped and relooked at as part of our strategic planning process in 2004. We on the Board of BPS take this mission very seriously. The mission of the Board of Pharmaceutical Specialties is to improve patient care through recognition and promotion of specialized training, knowledge and skills in Pharmacy and Specialty Board Certification of Pharmacists.

On this slide are the currently recognized Pharmacy Specialties. The first one was Nuclear Pharmacy in 1978, then we had Nutrition Support followed by Pharmacotherapy in the late 80's

and the early 90's, Psychiatric Pharmacy. The last specialty to be recognized was Oncology Pharmacy, but that was twelve years ago. There are some people on this panel up here and many of you in the audience who may remember those days, but for most of us, this has been a new experience.

This chart may seem familiar to some of you who lecture on this topic and use this to train students, but each year on the BPS website, we produce this slide, which tells you the number of specialists in each of the various specialties. As I stated, at the end of the October exam cycle, we reached a new milestone, almost 8000 pharmacists are now certified as specialists by BPS. Each of these charts has taken out those individuals who have failed to recertify and they are not included in these figures. You can see that some of our specialties remain relatively constant in terms of the numbers of specialties, but pharmacotherapy, specifically, has continued to increase in size dramatically.

Well, how is a new specialty created? I certainly had to go back and review some of the rules about specialty creation. The BPS Board has a formal method of approaching the development of a new specialty. There is, on the BPS website, a Petitioner's Guide for Recognition of a Pharmacy Practice Specialty. Any group wishing to petition BPS for recognition of a specialty, has to address seven criteria to document a case for this new specialty. They need to develop a petition and request formally that the BPS consider that petition for the recognition of a new specialty. Information has to be presented to support and defend each of the criteria. There are seven of those requirements and the criteria are listed here. The petition that we have received has, in fact, been reviewed to ensure that it has addressed these criteria.

The first criterion is that the public and pharmacy profession need a new specialty; that services of the Specialty Practitioner can be better provided by a specialist than by a generalist or other healthcare professional; and that the public health and welfare may be at risk without the specialist's services.

The public and healthcare system must have a clear significant demand for the specialty. A reasonable number of pharmacists who spend most of their time practicing in this area must be documented. A specialized knowledge is required to practice in the specialty area. This specialized knowledge is a pharmaceutical science based in biological, physical and behavioral

sciences. The specialty may not be based solely on the practice environment or managerial, procurial or the technical services of pharmacy. These specialized knowledges must result in specialized functions that are performed by this individual. In addition, there must be education and training available for the specialty practice and, finally, there is a transmission of knowledge in the specialty area through books, publications, symposia and professional meetings.

Well, how did we get to where we are today? In line with BPS's mission to encourage various specialty practice areas, the BPS Board asked itself, 'Is BPS providing the credentials that pharmacy profession and the public need for the present and the future?' As part of our strategic planning process, we had heard, in various discussions around the profession, that there was a need for an Ambulatory Care Practice Specialty. We actually held focus groups at meetings of ACCP, APhA and ASHP, and heard lots of pros and cons regarding a specialty in the area of Ambulatory Care. Most of that pro and con discussion was based on people talking about this specialty as though they knew what they were talking about, but it was very difficult to determine that everybody was talking about the same thing.

So, BPS, after hearing a lot of these comments, elected to conduct an initial role delineation study or, what is called, a Job Task Analysis, to bring at least some initial cohesiveness around what that discussion really meant. In other words, so that we were all talking about exactly the same thing, we wanted to do the initial task analysis or role delineation study, which would be necessary before any other process to develop a new specialty. That report was, in fact, released to the profession in July of 2007.

At that point, the BPS needed to back up and say, okay, is there anybody out there interested in bringing forth a petition based on this role delineation process? And, it turns out that there were three groups, actually three professional organizations (ACCP, APhA and ASHP) that formed a group to jointly develop a petition to BPS to recognize the Ambulatory Care Pharmacy Practice. That petition was delivered to us in early November.

While BPS doing a role delineation study was not a part of any of the other professional BPS specialties that had been recognized, it was, in fact, a very logical and appropriate step for BPS to take and was permitted by our specialty recognition process.

We are now at the next stage of that evaluation process. We're here to gain information from the profession to advise BPS on what the action should be. That action, again, would be to either approve or to not approve, Ambulatory Care as a Specialty Practice area. I want to reiterate the BPS has not made up its mind about whether an Ambulatory Care Specialty would be successful or it should be approved. What we're here today to do, is to get your opinion about the petition as it is.

So what is the timeline for that petition review process? Well, we've just begun. This is our first open hearing. As I indicated, we just received the petition in November. It was posted expeditiously to the website. Many of you have probably looked at that petition. I would certainly advise you to think twice before you push print. The Petition alone is 90 pages and the entire document with appendices is well over 1000 pages. So, again, I hope most of you have had the opportunity to read it, but again, be careful when you push that print button.

This is the first open hearing we have had on this topic, so you may hear some new things here, or you may not, depending upon your involvement in the process. We will also be conducting open hearings at the APHA Meeting in San Antonio, which is in April and also at the ACCP Meeting which is here again, in Orlando in April.

Depending on the need and logistics, there may be other open hearings that we may conduct at other meetings if requested. We hope to have all the input necessary the Board needs to make the decision in the first half of 2009.

So what's the procedure for this open hearing? I'm going to ask that the individuals at the head table introduce themselves. These are members of the Board of BPS that are here at this meeting and we are here to hear your individual comments for the petition or against the petition. So, before we go much further, I'd like to have the members of this table introduce themselves.

Rebecca Finley: Good morning. I'm Rebecca Finley and I am starting my second year of my second term on the BPS Board. In my day job, I'm Dean of the Jefferson School of Pharmacy in Philadelphia.

Susan Goodin: Good morning. My name is Susan Goodin and I'm actually a newly appointed member of BPS. I'm a Board Certified Oncology Pharmacist. In my day job, I am a Professor

of Medicine at the Robert Wood Johnson Medical School and an Associate Director of the Cancer Institute of New Jersey.

Dick Gourley: Good morning. My name is Dick Gourley and in my day job, I'm Dean of Pharmacy at the University of Tennessee. I currently serve as a member at large of the American Pharmacists Association Board of Trustees and, as such, serve as the Board Liaison to BPS. I did serve six years on BPS and three years as Chair in a previous life as well.

John Murphy: I'm John Murphy, Professor and Associate Dean at the University of Arizona College of Pharmacy. I have twenty-two more days on the BPS Board serving the end of my three-year term and I'm BPS's Liaison to ACCP.

Jannet Carmichael: In the interest of full disclosure, my name is Jan Carmichael. My day job is at the VA Healthcare System in Reno, Nevada, where I'm the Pharmacy Executive for VISN 21. I also was a member of the BCPS Specialty Council for five or six years and have been on the BPS Board now for four, I believe.

So, what's the process here today? Any individual is welcome to get to a microphone and speak. We are, however, trying to develop a verbatim transcript of the hearing today and I would request that all speakers step to one of the microphones in the room and identify themselves and wait to be recognized so that we can make sure that we get your name and all your comments.

Please state your name clearly and identify where you are from and any other comments you'd like to make in terms of your background. We'll try to keep some sort of continuity to the speakers and there's no attempt to alternate any kind of pro and con comments. I'll just call on people as they approach the microphone. You are welcome to react to another speaker's comments if you feel inclined to do so, but please do so in a polite way. This is not a place for any kind of heated arguments.

The BPS Board Members are really here just to listen to your input. We are, again, free to comment as well but I will tell you, it is not our intent to comment very much about what you have to say. We are here to listen and to understand the comments that you want to make about the petition and BPS' petitioning process.

If you have questions that I have not addressed in terms of clarifying how the process works or what will happen with the petition or what will happen after the petition, please feel free to ask those questions as well.

The hearing is scheduled to go until about 11 this morning and if there are enough comments to warrant that, we'll continue until that time. If there are speakers left at that time who still want to comment, again, we have no specific timeframe but we would encourage you to try and just observe whether there are a lot of people waiting to make comments and if there appears to be a free mike, feel free to step to the mike if you have additional comments you want to make.

At the end of our meeting today, if you wish to make written comments as well, please send them to the Board of Pharmaceutical Specialties to the attention to the Ambulatory Care Comments at our address, or you can e-mail them also to the address shown on the slide. The entire petition is, in fact, on the BPS website where you can find both the Petitioner's Guide and a variety of other information about this petition as well as the other BPS specialties.

So again, I want to thank you, and we'll now open the microphones for your comment.

Sarah Ray: My name is Sarah Ray. I'm a Pharmacist in Milwaukee, Wisconsin. I'm also our Community Pharmacy Residency Program Director and I have the BCPS Credential from 2002, so I'm working on recredentialing there. I am in support of the new Ambulatory Care Pharmacy Specialty.

It was a struggle for me to decide whether to do the BCPS or not, just because of my role in Ambulatory Care Clinics and our community pharmacy environment. I did achieve the BCPS so I'm happy and it's a very good way to remain current in the literature and do the PSAP Modules and just stay up on what is going on in all of Pharmacy. But I feel that the new credential will be very helpful to my community pharmacy fellow practitioners, most of whom have not seen the benefits of achieving the BCPS. And I feel they will look at the Ambulatory Care Credential as something achievable for them and something meaningful that they can bring into their practice that will make them a better practitioner.

And, certainly as a Residency Program Director, I feel that's something we can impart upon our Residents as something valuable and something that will help sustain the profession and help continue our MTM efforts. Thank you.

Binita Patel: I'll continue the Milwaukee theme. I'm Binita Patel, I'm the Assistant Director at Froedtert Hospital of Ambulatory Care Services. I'm also the PGY1 Community Residency Program Director at Froedtert Hospital. So, my comments echo Sarah's, in that every time we struggle to put our pharmacists in these positions, and these are challenging positions when we're placing them in physician offices. The more specialized we are, the more credentialing we have and the more education we have towards that, I think, would improve developing those services and help us with those challenges that we face in the Ambulatory Care world.

As we train residents and residents even become more trained in a PGY1 and then a PGY2, this is something else that would further their education.

Jan Carmichael: Just so you know, Jackie is on the staff of BPS and we've tasked her with getting the names of people who are testifying, so it probably would be helpful to Jackie if you just make contact with her if you plan to make a comment either before or after and make sure that she has your name correct. Thank you.

Diane Cappelletty: My name is Diane Cappelletty and I'm the current President of the Society of Infectious Disease Pharmacists and we've prepared a statement in conjunction with the ACCP ID PRN Group in terms of addressing the specialty examination.

This group wishes to voice our resistance to the petition to recognize Ambulatory Care Pharmacy Practice as a specialty in medication use for preventative and chronic care. And in doing so, we by no means wish to diminish the value of Ambulatory Care as a specialty, however, we are opposed to the additional specialty examination.

To the Specialist groups, such as ourselves desiring to have recognition by examination instead of by portfolio review, the process just does not seem to be equitable and there are numerous specialties that may desire to deserve recognition by examination, Critical Care, Pediatrics, Transplantation, in addition to Infectious Diseases. Currently, Nuclear Medicine, Nutrition, Oncology, Psychiatry, Pharmacotherapy and now possibly Ambulatory Care, may reserve

specialty certification by examination, but Infectious Diseases and Cardiology are reviewed by portfolio review instead of specialty examination.

As the landscape of Pharmacy practice evolves, we must use the certification process. We agree with that completely and we call on BPS to really more closely examine the certification process and make it more equitable between the various specialty subpractices.

So we ask that you do not approve the current petition for Ambulatory Care, but rather re-examine the certification process so that all pharmacists practicing in specialized roles, have the opportunity to demonstrate their specialized knowledge by examination or one standard certified process. So again, we thank you for the opportunity to speak and again, it's more the process rather than this individual petition that we object to.

Dick Gourley: As a comment - Dick Gourley Board Liaison - when the added qualifications came to the table, I happened to serve as Chair of BPS, and both Infectious Disease and Cardiology did have the opportunity to apply and put a petition in, they chose not to, to go to added qualifications instead.

The process of BPS is such that we do not create petitions. Petitions are created by you, the practitioners and practitioner organizations that submit them to BPS, so that it's clearly within your purview. If you wish ID to be a specialty recognized by certification, to go through that process and file a petition.

Diane Cappelletty: And I do understand all of that and we have looked at that process and it is, actually, quite an expensive process as well. As I understand it, and I could be misinformed on this particular issue, but this petition isn't coming just from an ambulatory group of practitioners, but rather two or three larger organizations coming together that have a greater ability to offset the financial implications of certification.

Dick Gourley: Actually, every one of the Board Certifications, the five that we have currently, had a sponsoring organization and so this is the first time we've had three majors sponsor. Nutrition had, I believe Aspen and ASHP and I don't think ACCP sponsored that one. But, there have been anywhere from two to three sponsors of most applications, except for Nuclear which was APhA in the beginning.

Rebecca Finley: Psych and Oncology were by ASHP only.

Dick Gourley: Thanks. So the practitioner groups, if you look at all three of the organizations that are sponsoring, there are a large number of Ambulatory Care Practitioners in each organization. So it's the organizations, through their membership, that encouraged this to occur.

Diane Cappelletty: And again, I think it just disadvantages the smaller subspecialties with fewer practitioners in it, given the cost offsets that a larger group of practitioners will more easily offset that price than a smaller subset of individuals.

So we're not opposed to the process and we believe certification is absolutely necessary, it's just a better means or a more consistent means by which we would like to see it performed. I have yet to sit at the table with this, but I will as President of SIDP in the upcoming months. As I understand, there's a meeting scheduled in January to look at a proposal being put forth by ACCP in which it's maybe a two-part examination process that is being raised as a potential for certification. And, that is, maybe Part I being the general examination and Part 2 maybe being a subspecialty examination. And again, by that methodology, would it be financially a bit more equitable for all subgroups to participate in such a process as opposed to the way that the structure is right now.

Rebecca Finley: One other thing I would just make the comment, you've used the term subspecialty. None of these specialty areas have been considered subspecialties. They are all specialties and meet the criteria that have been set forward by BPS, so I'd also encourage you to look at the petitioner's manual for the BPS, in particular Criterion C, which addresses number and time. So, I just want to make that clarification for the audience that these are not subspecialties. The five specialties you see there are specialties, given the definitions of BPS, and, also, those are the criteria by which Ambulatory Care is being judged.

I understand the cost issues. I was a petitioner myself on the last petition and a significant amount of fund-raising does have to go on but we encourage everybody, and BPS staff is available to consult with any group who is interested in seeking a designation as a specialty.

Diane Cappelletty: It's probably just my mis-speaking for subspecialty. I tend to think in that general medicine model in specialty within general medicine, is that offset. The word sub just came out, but nothing was meant by that. Thank you.

Alvin Goo: Hi, my name is Alvin Goo. I'm at University of Washington and Harborview. I'm a Clinical Assistant Professor at the School of Pharmacy at the University of Washington and the School of Family Medicine.

I was on the initial workforce in 2007. Initially, I was a little bit ambivalent whether we should be petitioning for a specialty, but as we worked through the process and delineated all of our roles and our daily functions, it became pretty obvious that there are added qualifications. So I would support the specialty and I think it will enhance our profession and our ability to move forward in this financial crisis where I think we need more and more specialty or qualifications and certifications, so I would support the process.

Katie Suda: Hi my name is Katie Suda, I'm an Associate Professor at the University of Tennessee in Memphis. Before I make any comments, I do want to make a disclaimer, that I am not BCPS Certified. But I have supported BCPS Certification in several ways, as a few of you know in the room, as well as encouraging my residents and students to pursue the examination.

First of all, I would like to ask a question because I always thought, as well as I tell my residents and students, that this exam is a general pharmacotherapy examination focusing on every aspect of medicine for the most part, including pharmacoeconomics, biostatistics, study design, drug information, oncology even on the Pharmacotherapy exam. And I'm wondering, how would the Ambulatory Care exam be any different from the current Pharmacotherapy exam.

Jan Carmichael: Well, there's a lot of questions in there and I appreciate them. BPS responds to petitions as they come forward. In this case, we've gone through a process of role delineation in which you go out and ask people who are actually practicing or you think are practicing in that area, what they do. Out of that Domains of Practice are developed.

And so, what we would do is look at whether or not these people are, in fact, functioning at a different level. That information was channeled into the process of petition development.

So, perhaps one of the petitioners could address how you went about the process of looking at the role delineation study that has been done on Ambulatory Practitioners and distinguishing it from those other specialties that are currently in existence.

Cynthia Brennan: Thanks. I'm Cindy Brennan and I was one of the petitioners from ASHP. One of the things we did during this process, is put the Pharmacotherapy role delineation next to what we had seen from the role delineation study and really analyzed whether there really were differences in the various domains. Certainly, there are overlaps. I mean there's no question that there are overlaps in certain areas, but we were able to identify enough differences so that we felt that Ambulatory Care, in fact, was a specialty distinct from Pharmacotherapy and the entire body of the tasks that were identified in Pharmacotherapy as compared to Ambulatory Care Pharmacy practice. Those are all part of the larger petition, but we did actually identify very distinct practice domains and tasks.

Jannett M. Carmichael: Do you have more questions?

Katie Suda: I do thank you. And I do applaud what you're doing. I think it's important that there is currently, besides Pharmacotherapy, Nuclear Pharmacy, Oncology, etc., that there are other specialty examinations possible available for practitioners.

However, there have been other specialty groups that have approached the powers that be in these various organizations and have been told not to even pursue the specialty exam, because of either the monetary amount that they would pay to take the exam, would not even equal what it would cost to put the exam on. And I am an Infectious Disease trained Pharmacist. I did two Fellowships, Residency and I train in the area of Infectious Disease and Medical Literature Evaluation. I'm also the Director of the Drug Information Center.

So, although my area of interest is diverse, I'm wondering if this is the right thing, not only for these practitioners in the area of medicine but for the profession, our students and the patients. If our purpose is to improve patient care, I'm wondering if this is the best way to really do it. But thanks for considering a new specialty and I look forward to hearing everybody else's comments.

Cynthia Brennan: Let me just respond to one thing. One of the other parts that we wanted to make sure, as part of this process, is we did a couple of surveys, one to Ambulatory Care

identified practitioners as well to the employers of this group of practitioners. We wanted to make sure that there was a large enough cadre of specialists in Ambulatory Care to really make it worthwhile financially. I mean there is a return on investment that we have to think about or the business case for doing these exams.

The surveys were sent to over 5,000 practitioners and lots and lots of employers and I can't remember the exact numbers, but we got a large number of responses out of that demonstrating that there would be a large number of practitioners/specialists that would immediately take this exam and then showing with the large growth curve of both community practice residencies as well as PGY2 residencies in Ambulatory Care that there would be an increasing number.

So, adding to that slide that was shown a little bit earlier, that there would be increasing numbers each year of Ambulatory Care Specialists that would continue to take the exam and again make it worthwhile.

Rebecca Finley: Thank you. I know the petition has only been posted on the website a very short time and probably many of you have not had the opportunity to look at it. I would encourage folks to do so. Even following this open hearing, you can submit written comments and you can also show up at one of the other open hearings.

I think comments that would be helpful for the Board, again for example the last comments regarding BCPS versus Ambulatory Care, is to look at Criterion E - the specialized functions – and the comparison that the petitioners have done in comparison to Pharmacotherapy. Please give us your feedback specifically on those points beyond just opinions, which will be very helpful. Again, I know people haven't had a chance to read the petition in its entirety in all likelihood and to try to target those comments that will help, it will really help the BPS Board in their deliberations.

Barbara Prosser: My name is Barbara Prosser and I'm not an Ambulatory Specialist so, I feel kind of funny being in the room. I actually work in the Home Infusion Sector of Pharmacy. I applaud your efforts, because I really believe that it does transcend a lot of pharmacy practice. There is Pharmacokinetics involved, there's Nutrition involved, we touch all aspects of pharmacy, but there certainly is specialty care being delivered in a specific setting, just like in the

Home Infusion world. There are things that happen in the Home Infusion world that do require a specialist.

For instance, we are one of the first companies who have set up a PGY1 Residency in Home Infusion, that has never been set up before, because it is a unique practice setting. I'm encouraged to see this activity, I'm encouraged to see that maybe we could potentially recognize specialists in settings because the care of a patient is very different in the home. The monitoring of lab values is very different in a home setting than it is in a hospital where it's a controlled environment and they're not eating a bag of potato chips while they're on their TPN.

So, it is different and I applaud your efforts and I'm actually very anxious to see what happens because I think it may pave the way for somebody like the Home Infusion sector to achieve the same thing.

William Greene: Bill Green with St. Jude's Children Research Hospital. I'm formerly a Member of the Specialty Council on Pharmacotherapy and I am Board Certified in Pharmacotherapy. Perhaps this is a question for Cindy, I'm not sure. But, as I recall from the role delineation survey, there's really a dichotomy in roles between those who practice in Ambulatory Care Clinics in a collaborative setting with physicians seeing patients, examining patients and that type, as compared to those who are in community pharmacy practice who may engage, to some extent, in medication therapeutic management. There is much more of a business aspect and that type of thing. I'm curious about the petition and credentialing, and how it, and perhaps even with Home Care, how is this credential going to relate to the really kind of heterogeneous mix of practice settings in Ambulatory Care?

Cynthia Brennan: We actually looked at that and we tried to sort of remove the practice setting from the actual practice, and look at the tasks that people were doing. We recognize that there is a large variety of practice in every area actually: in hospitals, in clinics, in community practice and we know that we're going to continue to need a large cadre of generalists. But what we're really looking at is in, across those settings, there will also be a need for Pharmacy Specialists in Ambulatory Care, for those complex patients needing the higher level, some of the behavioral changes, the chronic care, preventive care, management of those patients.

So, what we're really looking at is probably a group of generalists like we probably have in the hospitals right now, General Practitioners, as well as Specialists in Ambulatory Care, to be able to take care of those very complex patients that more and more of us are seeing across settings, no matter what the setting is. So I think this is applicable to all settings. We've seen some outstanding community practice settings as well as some outstanding clinic-based settings or hospital-based settings. Hopefully, it will be across all settings.

Since we're at ASHP, I'd also like to make sure that everybody knows that part of the reason that we supported this, is there was an interest from our members and we want to make sure that if there are other specialists that feel that they need the same type or would like the same type of review and discussion about specialty recognition, you just need to let us know. We heard sort of an uprising from our Ambulatory Care Specialists and so we pursued this but, as somebody was saying, maybe Home Care also. I just want to make sure that you let us know, keep us informed about other specialties that might require some of this type of look at specialty recognition.

Judy Beizer: I'm Judy Beizer. I'm from St. John's University. I'm also President of the American Society of Consultant Pharmacists, though I'm not speaking for them at this point. We haven't prepared a statement, though I'm sure we will. I speak from the experience of having been involved with the Commission for Certification in Geriatric Pharmacy and very involved with development of that specialty exam. So I appreciate the amount of work that goes into developing the petition, developing the exam, so I appreciate Certification.

But my concern, across the board, is what difference has it really made and how much difference has it made in the lives of the pharmacists who have gotten Certification. We know it's a good thing, but how have we publicized it and how have we made sure that it makes a difference in peoples jobs, in their hiring and that Physicians and policymakers understand the importance of Certification. That's something we all need to work on together and show that it makes a difference.

Jan Carmichael: Just to comment, Judy. We were talking before the meeting about when the last petition was received in Oncology, the needs assessment criteria relating to knowledge and skills and the amount of training programs and stuff that were available. We actually have come

a very long way in the last twelve years in terms of the number of residency programs, the number of training programs, we were even commenting about ACPE requirements that required certain kinds of rotational experiences for students in various training.

So, while I fully support your comments, and we need to do more, it is pretty amazing how far we've come just since the last specialty was recognized in pharmacy, and it actually was kind of rewarding to look at the petition in terms of the number of opportunities for training that were available since the last petitioner came forward.

Judy Beizer: So much of it is still internal within our profession and, if we're really going to be recognized and paid for our services, other people have to recognize it. We are still our worst enemy in not telling everyone what we do and the difference we make in people's lives. And by having a specialty in whatever area, it really makes a difference.

Yes, in some academic settings you may get help towards promotion or in the VA System it may help with the pay scales. But, in many other differences it's like, "Oh, that's nice," and people do it because they want to do it for themselves, but we haven't proved what difference it really makes. We all need to work together on that.

Dick Gourley: I agree with you that there needs to be more done in that line, but as you say, the VA does recognize that as does the Public Health Service, in terms of pay scales. We recognize it in the University in our case, that if you're Board Certified, there's a stipend that's added to your base salary every year. But as we look at individuals, I think the self actualization of what it does for them as an individual practitioner is something that's very hard to value, but it's very real. So the more that we get involved and make sure that other organizations understand the value of that, that's extremely important and I think we all have to work on that.

Marie Smith: Good morning, I'm Marie Smith and I'm Department Chair of Pharmacy Practice at the University of Connecticut School of Pharmacy. And I have three disclosures to make. First, I would have to disclose that I'm an Amb Care has-been, one of the earlier Am Care folks in the world I guess. Second would be, for a number of years as an ASHP staff member, I was the staff member who was responsible for working with the earlier specialties, such as Oncology and Nutrition Support to get that process moving. Most recently, is in my present role as a

Department Head in the State of Connecticut, I have a lot of activity going on with commercial payors and with the State of Connecticut, the state being a very large healthcare payor, as many of us know in our states. So with that, I'd like to pick up on where Judy left off.

Given the background I gave you, my perspective would be:

One, I'm very pleased to see that the organizations and sponsors have brought forth something for us professionally to look at, as a new specialty, which I think is just an evolution of our profession and our practice.

Second, we have to separate out, I hope in the decision-making process here, the issue of impact, which I think is Judy's comment. The first impact would be a personal impact. What difference does it make to me as a practitioner? I think that's probably what the process has been focused on a lot. I would say that now is the time to either enhance, because I will admit I haven't kept up with every little thing BPS has done, but either to enhance or really put emphasis on the overall professional impact.

Having worked closely recently with major commercial healthcare payors and trying to go to corporate offices and speak to them, which is in my backyard in Hartford, and I can get through that door and I can make the case, and I've gotten to a contract phase. But what really stopped everything, was the whole conversation, which is not with pharmacists, which is not with physicians or medical officers, it's with legal, it's with the real finance people in the payor world, about how do you differentiate yourself from other professionals and what credentials do you have.

I can make a case, and I have made a case, for number of credentials, but most of the things we're focusing on are in the Ambulatory Care arena, whether they're in Primary Care or in Community Pharmacies, the setting is irrelevant, but having a strong credential to bring to that commercial payor world, I think would strengthen some of our abilities to move forward as a profession.

C. Edwin Webb: My name is Ed Webb, I'm Director of Government and Professional Affairs for the American College of Clinical Pharmacy. I was one of the six folks on the task group tasked with developing the petition and I'm here mostly to show you that Cindy is not the only

one that has to defend the work, not defend, but articulate the work. It was a three organization effort with six folks, three from staff, three from the Practice community, supported very ably by a Technical Consulting Group that helped us put the petition together. So I want you to be fully aware that it was a team effort.

Also, obviously in the spirit of full disclosure, ACCP was the petitioning organization for the Pharmacotherapy Specialty and, obviously, had some interesting discussions internally about whether or not our role in development of another petition that is potentially, at least in some folks' minds, competing with the pharmacotherapy credential, whether that was an appropriate thing for us to do. And I just wanted to share with you that in the context of that overall strategic evaluation of ACCP that we did feel that it was an important thing to do.

Also, in the spirit of being a profession that theoretically prides itself on being evidence based, I want to encourage everyone in this room who reviews this process to look at the petition and read it carefully and compare it to the blueprint of the pharmacotherapy exam and make your own educated decision about whether there are sufficient differences in order to generate your own idea of support for this.

We believe we've put together a petition that makes a good case but there's no petition that's perfect. The notations that have been made by folks about the overlaps in domains are real. None of these existing specialties are silos. The pharmacotherapeutic management of patients has a lot of common elements in it, across all of the existing specialties, much less this new one. So we're not operating in silos here but we need to examine this in a really important way.

Also, in the spirit of disclosure, I do want to let you know it was mentioned by our SIDP colleagues that ACCP has published a pre-publication draft on our web site of a report by our Committee on Credentialing affairs to encourage a look at the long-term framework and examination process for specialty recognition. We have 22 practice and research PRNs. All of them in the ideal world, were money not an issue and demand not an issue, would like to proceed with the possibility of being recognized as specialists under the existing framework. But there are a lot of challenges there, and so we encourage you to look at that piece.

We think that the profession has to evolve its credentialing framework in an appropriate way that aligns with degree-based education, that aligns with residency training for the future. Those things need to be linked together and added up.

The process we have is the process we have; it needs to evolve. And, at the end of the day, ACCP felt that bringing this petition forward with our two partners was an important thing to do to stimulate this dialogue. And to encourage all of us to think seriously about what specialization means in pharmacy, what certification as a specialist means, and how we move it forward to address the concerns that have already been raised about what it means to the rest of the healthcare system in bringing value and quality to patient care and to the rest of the healthcare system. Thanks.

Melissa Bourque: Hi, my name is Melissa Bourque, I work at the VA Medical Center in Maine. I am the Coordinator of Student Education and a Coordinator in one of the Ambulatory Care Clinics, the Coumadin Clinic. I'm only here at this meeting because I'm taking the CACP exam, this weekend. Ten years ago when I got out of my Amb Care residency I probably should have taken BCPS then. So, in full disclosure, I'm not certified and I have not read the thousand page petition. So, I'm not really sure of the specifics on how the two certifications differ. But I do know I have put off pursuing the certification up to this point because it's been 15 years since I've worked in Critical Care.

I did a Post Bac. PharmD and a specialty residency in Amb Care, and I haven't made an IV in fifteen years. And so critical care and other things are so far removed from what I do, the thought of having to go through that full process. And for myself and my colleagues that work in primary care in the VA, the different processes for getting certified for Coumadin, for lipid, for hypertension all the different certifications, certificate programs. ALA has a program, the CACP has a program. If you do a lot of diabetes, you can become a CDM. There's really nothing for us and so I have to say I really put off doing that. I know it's there and I could do it, and if this process doesn't go through I probably will do it. And, yeah, I should have done it ten years ago, but I didn't.

To speak to the comments about reimbursements, being a VA person, once you get maxed out ten years in the system at a 12-10 there is no financial incentive to do the BCPS. It's just the thing to do. Thank you.

Steven Riddle: Hello, my name is Steve Riddle from the State of Washington, and I'm sorry my voice has traveled further south on this trip than the rest of my body so bear with me. I've been in practice now for a little over 20 years. And the last 8 I've been working in an area, have been privileged to work with folks who are providing this type of Ambulatory Care Specialty Care, managing these extremely complex patients. And my experience has been a learning curve in realizing the complex needs of these patients and the skills necessary to manage them appropriately.

When you look at the current state of healthcare and the future state of healthcare, I believe we're going to see this tidal wave of patients that need this type of care. I think we all are aware of that.

Recently, there was a report on the medical home model, that care model in a draft I looked at from the American College of Physicians, talked about primary care physician based model with care and how that was going to be the wave of the future. Nowhere in that report was pharmacy specifically mentioned and there was some backlash about that amongst a number of e-mail lists that I sit on. And I think this is exactly the type of certification, this specialty recognition, that can help us in being at the table with those physician groups as we begin to look at future care models that are going to address real patient needs.

So, I would encourage everyone here to support this realizing that there isn't a lot of overlap and that specialization can be a tricky discussion amongst all of us as we begin to further specialize in pharmacy practice.

I also would like to comment on the speakers, the commenters previously about third party reimbursement. I've also been talking to people about MTM now for some years and insurers, and they are looking for the credentialing, and they are looking for that certification. If we're going to move forward in MTM and actually be reimbursed for our skills, we're going to need certifications like this to move forward. So I would like to support this statement.

I would like to ask one question, perhaps of the petitioning group and I think that the comments I've seen on some of the listserves are confused because of maybe the general title of Ambulatory Care which seems to be a very large umbrella and folks aren't sure how they differentiate themselves under that, and I think we've heard some of those comments here today. So, perhaps maybe how that title was chosen would be something I'd like to hear about. Thank you very much.

Cynthia Brennan: So, fellow petitioners, make sure I get this right. We struggled a little bit with the title, frankly. One of the things that we recognized was that in the profession the ASHP accredited PGY2 residency uses the Ambulatory Care title, encompassing sort of the ambulatory care, primary care, family medicine family of PGY2 residency training. What we wanted to do is make sure that our language was consistent with that. At least, as we went to the BPS Board.

Frankly, if the BBS Board decides to call it something different, I don't think we'd mind that as long as we understand where that is. We wanted to make sure that there was the chronic care and preventive care links to this specialty because that I think is some of what differentiates us from say an acute care practitioner or maybe somebody who's certified in pharmacotherapy.

Mary Ann Kliethermes: Hi, I'm Mary Ann Kliethermes from Midwestern University, and I have two comments. First, along your comments, Steve. I'm involved with the section of Home Care, Ambulatory Care and Long Term Care. And we currently have a task force right now developing guidelines for ambulatory clinical practice, and I think that might help define the type of person that we're looking for for this credentialing. And I also would like to relay a story that I think may help in support of this petition.

I was invited to participate with a QIO in our State of Illinois. The QIO physician that was working there was charged with trying to improve MTM in the state and she brought different players to the table to talk about MTM. We had the American Academy of Family Physicians representative, AMA representative and a number of pharmacy folks in the state trying to implement MTM were there.

And it was interesting because the family physician group was fairly supportive of MTM but the AMA physician came in pretty strong against it, against another person coming in and telling

them what to do. And as the two hour meeting continued and the pharmacists that were there explained the type of work they did, the demeanor of the AMA representative actually changed and he said, "I like what you're telling me but how do I differentiate who can provide this and who can not?" So, that's just a story that may support it.

At that time all we could say is that residency, experience, training which is not that easy for a other professional to determine and understand.

Katie Suda: Katie Suda, University of Tennessee. I know that there's other certifications. I was aware of that when the person from the VA mentioned that. And I know that it's costly to pursue many of those or pursue like some of the certification programs. However, at least there are certification available. There's many specialties where there's no certifications. And if you look at the pharmacotherapy exam of the different therapeutic areas, Oncology which has it's own exam, has fourteen different diseases you have to know. So does GI and Cardiology. Infectious Disease has twenty-one different areas, disease states. One of them is HIV which, even though I'm an ID trained pharmacist, I never state that I'm an HIV practitioner because it's such a complex disease.

So, again, I'm not saying this is the wrong thing to do, I'm just really asking if it's the right thing and the best thing to do when other organizations have already made the monetary investment for these other certifications that are available for these practitioners. Thank you.

Jeri J. Sias: My name's Jeri Sias. I'm a Clinical Associate Professor at the University of Texas Cooperative Pharmacy Program. I'm sorry I wasn't here at the beginning. I didn't know how much APhA was on board on this, and I see APhA.net in the email but they've also been involved quite a bit in the Disease State Management Certifications. And so having their input and support with this would be helpful. Thank you.

Kelly Goode Kelly Goode. I'm an APhA Trustee. I'm one of the Petitioners on the Ambulatory Care petition. APhA is a copetitioner with ACCP and ASHP, so APhA is on board with this Ambulatory Care Specialty as well.

Jennifer Clemente: Good morning everyone. My name is Jennifer Clemente. I'm an Ambulatory Care Pharmacist from Harbor University Hospital in Detroit, MI. I'm also on the

board for the Southeastern Society for Health System Pharmacists. And, my comment is really about patient care. Some of you have thought about well how will this really impact patient care. And this is kind of how I look at it. I have struggled to convince students, as well as other practitioners, physicians, that what I do is specialized. How I take care of my patients required additional training And one of the things I'm trying to do, because the profession has recognized Ambulatory Care as something so important that now all pharmacy schools are requiring students to have an Ambulatory Care rotation, and so I'm struggling to create new practice sites and new clinics.

And one of the things I always come across is why should we pay a Pharmacist to do something that a PA could do or a Nurse Practitioner for much, much cheaper. And I have to constantly justify why pharmacists get paid what they do and why I would do better to help them serve their patients.

So, I just want to state that I really support this petition on a professional and personal level because what we do is very specialized and it would help us to really be recognized among the medicine field to be in those clinics. Thank you.

Katie Suda: I'm sorry, I just want to make one more comment. We just went through ACPE reaccreditation and I was vice-chair of the self study. And the ACPE requires a lot of things. Yes, they require an Amb Care component, they also require drug information skills. They also require a student's knowledge of biostatistics and clinical study design and medical literature evaluation but there's not any certification available on that. And many practitioners can say the same thing, "A certification exam will help me be recognized." I don't think that's unique to Ambulatory Care.

Jannet Carmichael: My intention in standing up was not to decrease your comments by any means. So, please feel free to come to the microphone if you have additional things to say.

I sense, however, that we're running to the end of comments. If I'm wrong about that, please let me know. We have about a half an hour left. Remember that your opportunity to make comments about the petition is not limited to verbal comments. After this meeting we will be having additional open hearings at the APhA annual meeting in San Antonio in April and at the ACCP

spring meeting which is here in Orlando also in April. And we may be having additional open hearings depending upon interest.

For those of you who do not want to make oral comments, we again invite your written comments, and for those of you would like to transmit your verbal comments into written comments we would also like to encourage you to do so. Please send them to BPS. Please take the opportunity to look on our Web site, where you'll find the entire petition which addresses the seven areas or criteria needed to become a specialty.

I repeat that we will not be making a decision on this petition until some time in early 2009. So you have months of time yet to gather your thoughts, your comments and send them to us, both pro and con. We are very happy to hear them all.

If there are no other additional comments, I want to thank you very much. I think we've had a very good discussion on both sides. We appreciate your thoughts, your professional ideas and your comments. Again, continue to send them to us. We like hearing from you. And if there are no additional comments, I'm going to close this hearing. Thank you all very much.

END OF PROGRAM