BOARD OF PHARMACEUTICAL SPECIALTIES OPEN HEARING

APRIL 26, 2009 – ORLANDO, FL

Terry Schwinghammer: Well, good afternoon everyone. This is the Board of Pharmaceutical Specialties Open Hearing on the Petition for a New Specialty in Ambulatory Care Pharmacy Practice. My name is Terry Schwinghammer and I'm the current Chair of BPS. We have a couple of other BPS folks here. First, is Dr. Richard Bertin sitting over here, the Executive Director of BPS, and Dr. Julie Wright, Chair of the Pharmacotherapy Specialty Council. I'll ask Julie to introduce herself.

Julie Wright: My name is Julie Wright, and I'm from Kansas City, Missouri, and I'm the current Chair of the Pharmacotherapy Council.

Terry Schwinghammer: I'll give some brief background information on BPS and this process, and then we'll open it up for comments from you all.

As you probably know, BPS was established by APhA in 1976, in response to changes that were occurring in the profession, indicating a need to officially recognize areas focused on specific knowledge and experience of pharmacists. Now there are almost 8,000 pharmacists who have been certified in one or more of the five current specialties of BPS.

The Mission of BPS is to improve patient care through recognition and promotion of specialized training, knowledge and skills in pharmacy, and Specialty Board Certification of pharmacists. And of course you know that the BPS Board does take its responsibility very seriously, as it is the profession's premier agency for specialty certification in support of optimal patient care.

These are the five existing specialties recognized by BPS. Nuclear Pharmacy was first in 1978, and the most recent one was Oncology Pharmacy in 1996, so there has not been a new specialty recognized by BPS in about 13 years.

This slide shows the numbers of BPS Certificants at the conclusion of the fall, 2008 exam. As you can see, there are about 8,000 pharmacists certified, the bulk of those are in pharmacotherapy. It's had about a three-fold increase since 2000, to about 5,500 BCPS certified

pharmacists now. Oncology has also seen excellent growth, about three-fold, and there are about 860 certified oncology pharmacists presently.

The BPS has a formal mechanism and procedure for approaching the development of a new specialty, and that is documented in the petitioner's guide for recognition of a pharmacy practice specialty, which is available for you on download at the BPS website, BPSweb.org. In short, a petitioner has to develop and document a case for the new specialty, and address seven specific criteria, which I'll talk about briefly in a little bit. Information has to be presented to support and defend each one of those criteria. The Petition for the Ambulatory Care Pharmacy Practice Specialty is lengthy. The petition itself is almost 100 pages, and in total with appendices, it's about 1,000 pages in length.

Once the Petition has been received, the Board receives input from interested parties and other experts, and then makes a decision as to whether or not to approve the proposed new specialty.

These are the seven criteria, outlined in the Petitioner's Guide that must be addressed and documented. First, the profession of pharmacy and the public must need specially trained practitioners in the specialty area to improve the health and welfare of the public. Importantly, the services of the specialty practitioners cannot be provided by generalist practitioners or by other healthcare professionals, or by currently available specialties, approved by BPS. Further, the public health and welfare must be deemed to be at risk without these specialized services.

Secondly, the public and healthcare system must have a clear and significant demand for the specialty. This demand can be defined as a willingness and ability to pay for those services.

Criterion C is that a reasonable number of pharmacists must practice in the specialty and devote most of their time to providing services in the specialty area.

Criteria D and E, specialized knowledge and specialized functions, require a role delineation study or job task analysis to be conducted. First, the practice in the specialty area must require specialized knowledge of pharmaceutical sciences, based in biological, physical and behavioral sciences. The specialty may not be based solely on the practice environment or certain managerial, procedural or technical services. The specialized knowledge has to be different from

that provided by or obtained by recent Doctor of Pharmacy graduates, and has to be different from those in other specialties already recognized by BPS.

Similarly, the knowledge and skills required to perform the specialized functions are acquired through education and training beyond the basic level attained by general pharmacists, i.e. recent Doctor of Pharmacy graduates, and has to be different from that of other existing specialties.

Criterion F is that pharmacy schools and other organizations must offer education and training in the specialty, but the training has to be different from that afforded to recent Doctor of Pharmacy graduates.

And lastly, there must be mechanisms for transmission of knowledge in the specialty area, through such mechanisms as books, journals, symposia, and professional meetings.

So how did we get to where we are today, with regard to this specialty? In line with its Mission, the BPS Board has given a lot of thought to the question, 'Is BPS providing the credentials that the pharmacy profession and the public need, both for the present and for the future?' Several years ago, as part of BPS' strategic planning process, the Board discussed what we saw as significant potential interest in a specialty more focused on ambulatory care or primary care. As we all know, that's a growth area in healthcare, and we were hearing from both BPS current certificants, as well as those who were not certified, that ambulatory care could be an important addition to BPS' list of certifications. So BPS held focus groups at meetings of ACCP, APhA, and ASHP and heard lots of pros and cons about this idea.

One clear message that came from all of that was that really there wasn't good consensus or agreement about what such a specialty would encompass, or what it would test. The BPS Board itself wasn't even clear or in agreement about whether what might be intended with the specialty or in fact what was needed. So, for that reason, BPS did something that really was new for the Board, and that was to conduct the initial role delineation study itself, to bring at least some initial definition to what either ambulatory care or primary care practice might be, what its domains might be, what the associated tasks and knowledge statements might be.

So BPS convened a task force of knowledgeable individuals to work with a psychometric consultant to carry out this role delineation study. Some of you might have participated in that task force. That report was released to the profession in July of 2007.

So, for BPS itself, doing the role delineation study was new, and not how the previous specialties began, but it seemed logical and perfectly legal and appropriate for BPS to conduct that study. It's permitted by our new specialty recognition process, and seemed to be an expedient way to really keep the discussion moving and focused, and provide a good set of initial parameters for future discussion. But once that report was released, BPS stepped back from the process and let the profession decide whether one or more groups were interested in proceeding with it. That is, to develop and submit a formal petition that's in line with our approval process.

So, as you probably know now, ACCP, APhA, and ASHP decided to jointly develop the petition to BPS to recognize the specialty of Ambulatory Care Pharmacy Practice, and that petition was delivered to BPS in November, 2008.

So now we're at the next step of the evaluative process, and that's gaining information from the profession to advise the BPS Board on its action. It's important to note that BPS has not made up its mind about whether an Ambulatory Care credential or specialty would be successful or should be approved.

Once a petition is received by BPS, it undergoes an initial review by the BPS staff in-house, to make sure it's complete and all areas have been addressed. And we're at the second bullet point here, which is receipt of input from across the profession in open hearings. This is the third of three such open hearings that have been scheduled. The first was at the ASHP mid-year meeting, right here in Orlando, in December, and the second was at the APhA meeting in San Antonio, earlier this month. So, with hearings now at all three major meetings of the organizations that developed the petition, in addition to accepting written comment, the Board hopes to gain a good view of the profession's feelings about this new specialty.

The Board hopes to have all the input necessary to make a decision at its next meeting, which is in June.

The goal of this hearing is to generate input that will be useful to the BPS Board when it's called on to decide whether Ambulatory Care Pharmacy Practice should be approved as a specialty or not. Any member of the audience is entitled to speak, either for the petition or against the petition, or to just make general comments if you like. But because we need to make a verbatim transcript of this hearing so that it can be shared in written form by all members of the BPS Board, we'd like to ask that all speakers come to the microphone in the room, and wait to be recognized to speak. When you do speak, please provide your name and your institutional affiliation, and any other context that you'd like to provide for background information. We'll take speakers in order, and it's fine if a subsequent speaker wants to refer to a previous speaker's comments.

The BPS Board people here, Julie and Dick and I, are here just to listen to your input only. As I mentioned, we have not made up our minds and don't represent the full Board's views about this specialty, so we won't be providing any opinions about the specialty in this hearing. We also won't provide any information about the petition or its content. The petition is well distributed, it's available on the website, and we hope that the people commenting here today are familiar with the petition.

The hearing can go until 4:00 PM if there are comments enough to warrant that kind of time, otherwise we'll just end it when it seems like we've taken all the comments available. There is no specific time limit on any given speaker but, of course, we hope you'll be courteous with respect to leaving time for others to speak.

In addition to this open hearing, you're certainly free to submit written comments by regular mail to the Board of Pharmaceutical Specialties at the address on the slide, Attention: Ambulatory Comment, 2215 Constitution Avenue Northwest, Washington, DC, or by email at BPSambcare@APHANET.org. BPS will continue to receive comments through the end of May, so we have a little more than a month remaining.

And, my last slide is the definition of the Ambulatory Care Pharmacy Practice proposed specialty as defined in the petition itself. I'll just read that for the record. 'Ambulatory Care Pharmacy Practice is the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with

patients, and practicing in the context of family and community. This is accomplished through direct patient care and medication management for ambulatory patients, long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self-management.'

With that, the microphone is open for comments, and I want to thank you in advance for assisting BPS in this very important process.

Mary Beth O'Connell: Hi. Mary Beth O'Connell from Wayne State. I am BPS certified, and I work in Ambulatory Care, and I have not read the full petition, so I was hoping to get a little bit more feedback on that. My question though, is, I found my BCPS to have served me well in my ambulatory care practice, and I go through the PSAP modules and feel that most of them kind of fit my needs. I look at this statement, and there's a few things that are different than BCPS, but, I guess I could be for this if the concept of a person who works in ambulatory care can either be certified through this process or BCPS, because I thought that that served me well.

And I'm kind of confused, because I thought we were going the route of adding added qualifications for ambulatory care after the BCPS. I do believe there is a certain set of skills and needs that are specific to ambulatory care. I'm still struggling with whether we need a completely different test. And if, at the end of the day, this is going to be required for reimbursements in the ambulatory care setting, I would hope that we would promote both the BCPS and an ambulatory care credential to be acceptable in that practice environment, versus making it two different silos.

Robert Talbert: My name is Bob Talbert. I'm from San Antonio, Texas. I'm also a Board certified pharmacotherapy specialist. I have one point of clarification because, even though I have sat on the BPS, I'm not really certain about this. There are seven criteria. Is it essential that all seven criteria be met in order for a specialty to be declared a specialty?

Terry Schwinghammer: Yes. The petitioner must document, and make a case for each one of those criteria, and you can refer to the Petitioner's Guide. They've addressed each one of those.

Robert Talbert: I guess my concern would be specifically relating to specialized knowledge, because the types of diseases that we see in inpatient settings, acute care settings, certainly do

carry over to outpatient settings. The percentage of each, the intensity of each may vary, but there are many overlaps in terms of principles of management. Many overlaps in terms of pharmacotherapy and monitoring of therapy, patient education. So I guess my question would be, how clearly differentiated is that particular criterion of specialized knowledge laid out in the petition? And I realize you're not here to answer questions. I only raise it as an issue.

Terry Schwinghammer: If anyone's here, one of the petitioners from one of the three organizations would like to respond to that question, that would certainly be appropriate,

Stuart Haines: Stuart Haines. One of the group of petitioners from the petitioning organizations, one of the authors of the petition itself. In the area of specialized knowledge and skills, we recognize that there are overlaps between Board certified pharmacotherapy specialists, as well as Board certified psychiatric pharmacists, as well as Board certified oncology pharmacists, because the domains of knowledge, in terms of pharmacotherapy have many overlaps. But we did find areas of knowledge in terms of wellness, disease prevention, patient advocacy, relationships and patient motivation, and certain skill sets, which came out in the role delineation survey, which we felt were distinct. So, there are overlaps, but there are areas of distinction as well, and we do lay those out in the petition itself.

Robert Talbert: Thank you.

Alan Zillich: Hi, my name's Alan Zillich, and in this capacity, I am serving as the Chair for the Ambulatory Care PRN for ACCP. And so, when this came about, about a year ago actually, I charged our Research Committee with conducting an informal survey of our PRN members, and we asked basically about their feelings related to this credentialing process. And so I have the results here, and I just thought maybe I would read some of them, to share with the group, because this constitutes about 1,100 total members, all of whom, in some way, shape or form, practice or have areas of interest related to ambulatory care.

This was conducted by our Research and Scholarship Committee, currently headed by Dan Longyhore. He's not here. I think the only person I saw here that actually was part of the committee that's here today is Candice Garwood. We sent this out to our PRN listserv, and we had a number of questions that we asked, but, essentially, there were two main questions that we

posed, and we posed them in two ways. One was to get qualitative responses, their verbatim comments, and then the other was a Likert scale of whether they agreed or disagreed with certain comments.

So the first statement was, ‘There’s a need for a specialty credential in ambulatory care’, and the second one that I’m going to talk about today is, ‘I have concerns about a specialty credential in ambulatory care.’ Before I tell you those results, I’ll tell you a little bit about the overall responses.

We have about 1,100 members in the PRN, and the responses to the survey constitute approximately 25% of that group. We had about 225 responses. Keep in mind this was sent out over our listserv, where not all of our members sign up for the listserv, so the questionnaire may not have reached everyone. We had representation from almost every state, a variety of different positions, 36% had clinical track faculty appointments, 40% defined themselves as a clinical pharmacist in some way. They practiced in a variety of office settings or practice settings, 35% were from teaching clinics, another 14% were from government or VA-related clinics. Approximately 60% of the respondents were BCPS certified. An additional 30% had no additional certifications, and there was a smattering that had related other certifications.

The answers to the statement, ‘There’s a need for specialty credentialing in ambulatory care’: Those who answered strongly agree or agree was 66%. Those who answered disagree or strongly disagree was 21%. And quickly, I’ll just read to you some of their qualitative comments that were summarized by our committee. Participants responding to this question as strongly agree or agree commented that the current BCPS exam was too general and that it contained too much inpatient assessment and not enough outpatient assessment.

Those who left comments questioned the need to demonstrate knowledge/skills in areas such as nephrology, oncology, critical care and nutrition, as an ambulatory care specialist. They felt that ambulatory care was a unique practice area that offered various other subspecialty credentials, such as diabetes education, clinical lipid specialists, asthma educators, etc. In the ambulatory care specialty, you may find a way to replace, or be equivalent to these. In short, it could be an umbrella certification for outpatient subspecialties. As well, responders thought that the BCPS did not adequately assess chronic disease state management, a critical component of ambulatory

care. This new ambulatory care credential would better define the roles of an ambulatory care practitioner.

I'm just going to skip the comments from those who responded neutral. But those that responded disagree or strongly disagree, commented that the current BCPS exam was sufficient to assess ambulatory care pharmacists, and that the exam may be weighted to test more outpatient and inpatient information.

Surprisingly, this argument was the exact opposite for those that were in support of the credential. As well, there were many comments about a concern that the specialty credential in ambulatory care would further subdivide the profession, and that this may weaken, rather than strengthen, our profession's quest for recognized provider status. They commented that the more subspecialties created, the greater the chances of confusing physician and mid-level practitioners as to what pharmacists can do. This confusion may lead to other medical professionals filling roles that would be best suited for pharmacists, because of an unclear understanding of the credentialing process or our standards.

Finally, some created a comparison to the specialties of physician counterparts, arguing that an internal medicine physician does not take an exam to be an outpatient internal medicine physician, or an inpatient internal medicine physician. Rather, he or she is defined by the practice location and not the credential. So those were summary comments from our statement about a need for a specialty credential in ambulatory care.

With regard to responses about the statement: 'I have concerns about a specialty credential in ambulatory care', 33% strongly agreed or agreed with that statement, while 54% either disagreed or strongly disagreed with that statement. Just quickly a summary of their qualitative comments. Participants that strongly agreed or agreed with the statement, felt that the addition of the ambulatory care specialty would water down the meaning of the specialty. They found that the Board certified oncology credential and the Board certified psychiatry credential were justified, because the management of these disease processes has fewer crossovers into general medicine than those assessed in the BCPS exam. As well, creating an ambulatory care specialty would not provide any benefit to ambulatory care pharmacists that practice in clinics, for one disease state or medication such as diabetes, dyslipidemia, anticoagulation. If the argument was that the

BCPS exam was too broad for outpatient practice, then an ambulatory care specialty would be too broad for those in concentrated areas of ambulatory care. As well, another certification means an increased cost for those wishing to take the exam and certify.

On the opposite end, those respondents who disagreed or strongly disagreed with the statement had fewer concerns that this exam may not be beneficial for those with specialty practices within ambulatory care, but the certification may serve as a foundation for medication therapy management reimbursement, as well as reimbursement for other clinical services. Also, it may help to differentiate between entry level PharmD practitioners and practitioners with advanced skill sets in ambulatory care.

So, that's just a quick summary of the results. We've been planning on trying to do a bit more in depth look at all the comments; there's quite a few of them. We don't have a whole lot of expertise in qualitative data analysis, so if we have any qualitative data analysis experts in here, it would be great, but I just wanted to share that with the group.

Terry Schwinghammer: Thank you, Alan. Two things. One, Dr. Bertin is sitting in the audience to make sure he has the correct spelling of everybody's name, so stop by and see him if he flags you down, to make sure we get that. And secondly, Alan, I would appreciate it if you would submit the full report of the PRN to BPS in written form, so we'd have that as part of the documentation.

Alan Zillich: How pretty or ugly do you want it?

Terry Schwinghammer: Legible is fine.

Alan Zillich: Okay.

Bill Miller: Bill Miller, University of Iowa. The comments I want to make really have to do more with the way BPS functions. I think that what we need is a conceptual framework for specialties. What we're doing is reacting individually to groups that believe a specialty should be formed. I was one of the individuals involved with pharmacotherapy, initially as an officer of ACCP and, clearly, our view at that time was, it was a very broad specialty. It wasn't by

location. It was broad. It didn't say hospital. We struggled with that. It said pharmacotherapy practice.

And so, from my point of view, now we have ambulatory care that's labeled by practice. The concern I have with that, is that focused upon the way pharmacists practice today, in those settings in which they practice. A couple of examples, where pharmacists that are ambulatory care practitioners now are moving into the inpatient area, is, if you look at the Joint Commission requirements for anticoagulation. It's a skill set that can be used in both settings. We look at transplantation, inpatient. From a patient point of view, coronary care is enhanced by providers that understand both locations. So, I'm concerned about this location piece.

It's interesting to me that the BPS found it possible to put forward a role delineation, but has been, from my point of view, somewhat resistant in looking at the concept of what specialties are today, and developing this framework. So, I think that that's what's needed, so that when we move forward with other petitions, we have some newer component.

I would argue, for example, with what Stuart had to say. I can tell you, since I do residency accreditations, that we expect wellness and prevention in all residency programs, and if you looked now at the task analysis of pharmacotherapists, you would find new things have been added to that practice that now constitute what that practice is all about. So, I think we're kind of looking backwards, and not updating things. So, to me, I think, these are just some issues.

I don't know if they need to be settled here through this petition, but I urge BPS to look at the broader picture and consider some of these things about location, structure and so forth, so that we can avoid everyone wanting to get a specialty that's really designed to be exactly what they do today, in their practice.

<u>Stuart Haines</u>: Stuart Haines again, University of Maryland, and one of the petitioners. One is a comment about the petition itself, and another is a personal comment. One is that we use the term ambulatory care practice in this petition. I've been on the record also as stating this at the APhA meeting, not to signify a location. And that was for the lack of a better term, and also to have alignment with the terminology with ASHP, PGY 2 residency training that is labeled ambulatory care practice. So the term in this instance is used to conceptualize a practice, a mode

of practice, not a location of practice. So that's to make some clarity, hopefully to what the meaning of our terminology is.

The second is a personal comment, and that's to agree with Bill, that the framework under which BPS recognition of specialties has made it increasingly difficult, I think, and the conceptual- being able to justify individual specialties under our current framework creates some challenges, and yet, we know that more and more pharmacists want to be specially recognized for the skill sets they have that go beyond what an entry level practitioner has.

<u>Deanne Hall</u>: Hello, Deanne Hall from the University of Pittsburgh. I don't have the BCPS, and I started studying for the exam about the time that the rumblings came for the am care one, so me personally, I stopped and said, I'm just going to wait and see how this all shakes out, because I don't want to take two exams. So, I'm looking forward to see which way we go. But I'm also director for our ambulatory care residency program, so I guess this is more looking at this exam as saying, okay, if you take this exam, you're now a specialist in ambulatory care. What about the ambulatory care specialty residency? So, if somebody goes through the am care specialty residency, do they also need to be BPS certified in am care to really be considered an am care specialist?

So, I guess my comment for the group is- I don't know if that has been considered, where that lies, and my resident had asked me the question when we were having this discussion, so, does this mean I need to take this exam? Should I take the BCPS? Do I need to take both? So I think we've been talking a lot about the exam itself, but just where this falls in line with our current practice of residencies and delineating specialists that way. Just kind of raising a comment or concern.

<u>Kelly Goode</u>: Kelly Goode, I'm also a petitioner. I'm a faculty member at Virginia Commonwealth University and I am BCPS certified. Actually, you would probably still have to take the exam. Doing a residency does not document that you have the skills and knowledge that are put forth by the exam. Currently, there are pharmacotherapy residencies, but you still have to take the BCPS exam to be considered to be a specialist. So that doesn't necessarily mean having the residency grants you all the things that are necessary to be considered a specialist.

Chris Papp: Chris Papp, Denver, Colorado. Board certified pharmacotherapy specialist since 1991. When this exam first came out, I supported it blindly, because I thought it was the right thing to do, and I still think it's the right thing to do. I think pharmacotherapy as a specialty is a process of pharmaceutical care, regardless of what setting it's in, or what patient population to a certain degree. I took this exam as a pediatric infectious disease specialist. I didn't clamor or even think twice about, oh this exam does not have enough pediatric questions on it, because the exam is about a process of being able to make the right decisions, whether it's in an ambulatory care setting, an ICU, a pediatric clinic. I have a certain animosity or concern about the whole subspecialization of pharmacotherapy in general.

The other concern I have with this particular petition is, the decision I think, around the cardiology and infectious disease added qualification process. At that time, you know, there was some question about whether those should be exam-driven specialty credentials, and at that point in time, the decision was to go to added qualifications. I think this might be a viable area where, if you needed added qualifications in ambulatory care, that maybe that would be a reasonable approach for this. But I see this more as a site-specific specialty, and not necessarily one that warrants excessive amounts of additional pharmaceutical care knowledge to warrant it as a specialty.

(PAUSE)

Chris Papp (?): I had notes and I didn't look at them. One other thing that I hear about the BCPS exam, and certainly, I've sat for it three times. I've never done PSAP, because I hate doing all that hard work for PSAP. It's much easier to resit for the exam. But, you know, there is an inpatient focus on the exam, or maybe not even inpatient, but certainly there are therapeutic areas that seem to be more representative. Maybe we should look at the item writing of the BCPS exam to include more ambulatory care questions, just as a secondary thought.

Mort Goldman: My name is Mort Goldman, I am at the Cleveland Clinic. I am Board certified since 1991 or 2, added qualifications in ID since about the year after they came out, I don't remember, I've done it a few times. It's really hard to read the petition on a Blackberry, although I've got my glasses here. But, one of the things that I actually noticed as I was paging through this, is that Criterion D, which is the specialized knowledge, and Criterion E, which is

the specialized functions that are listed one after the other. There's actually nothing specific. They've lumped the two together in the petition it looks like from the Blackberry version, so I can't begin to tell you if that's the actual real version or if that's just because that's what it gave me, but I am concerned that, if there are really seven criteria that you need to meet, or however many you had listed, that this may really not meet the knowledge criteria of specialized knowledge. I mean, there are certain pieces of the puzzle that ambulatory care folks don't need from the pharmacotherapy exam, the critical care pieces. But I would put it to you that they really better understand what happens if somebody in the hospital, in the critical care arena, when they come into the ambulatory care arena as well.

I think, to the last gentleman's comment, that we could expand or make sure that there's enough ambulatory care material on the BCPS exam. I think there are folks that are crossing lines all over the place in some of the areas that another person had discussed, in anticoagulation, in transplant, in cardiovascular disease, that I can't really give you the differentiation. Thanks.

Jack Burke: Hello, Jack Burke, St. Louis College of Pharmacy in St. Louis, Missouri. I was trying to decide whether these comments have already been made, but maybe be a little bit more overt in the question about the overall framework of specialty certification. I'm Board certified in pharmacotherapy and that has served me, and I think a lot of our faculty who practice in both inpatient and ambulatory care, well. But, as somebody who's been involved in residency training, it seems like there's a disconnect between our certification process and our training process, and that if we had a system in which there was certification that could occur after first year of residency that might get at some of those basic skills that go across all of the areas, and then a certification, second step, of Boards that might occur after those PGY-1, PGY 2 specialty residency programs. It seems like it would be a more consistent process.

Alison Bernknopf: Hi, I'm Alison Bernknopf from Ferris State University, and one of the things that I saw, when I saw the numbers of all the different specialties, is that there's a lot of people with BCPS, and I think what people aren't thinking about too, is, yes, ambulatory care might come in, but, BCPS isn't necessarily going away either. That's not what we're saying here. So, for those people that are crossing over, as long as BCPS remains what it still is, in that it covers both some of the ambulatory care issues and the inpatient stuff and all of the health management,

that it remains the same, then those who are doing the both, that BCPS would more cover them, then they'd take BCPS. Those that are more specialized in ambulatory care, that want ambulatory care specialty, then they go for ambulatory care, where they don't have so much focus on the inpatient. So, that's one of the things I'm torn with.

The other thing is, I can see the need for having a broad, over- encompassing thing. I think, as Stuart Haines said, that there are things that are missing, like health promotion and those sorts of things, that aren't thought about on the inpatient side, but at the same time, completely ignoring inpatient stuff is, when you get the picture of dealing with those inpatient things from an outpatient standpoint, then you can help counsel the patients and experience those things. But, my personal thing is, I'm kind of for it, because I think there's a need, but, BCPS isn't going away, and I think with the numbers that we have, you may see a drop in BCPS, but, I don't think it's going to be a drop that's going to cause it to go away, because there's enough people.

Mary Beth O'Connell: Mary Beth O'Connell, still from Wayne State. My other concern is, I totally believe in this whole process and I'm always concerned about the number of practitioners who haven't gotten any sort of certification. And I know in the past, from having looked at budgets and things like that, that we've always been challenged to try to promote this to get more people to actually take this. So, are there going to be enough funds within BPS to actually put this on, or will that be taking away funds from actually promoting, to try to get more people just to do the pharmacotherapy broad spectrum certification? So I think, when you have limited resources, is this the best place to go, when we really need- I think the bigger issue is to get more people Board certified.

Anne Hume: Anne Hume, University of Rhode Island. I've been BCPS certified since the second year it was offered. I didn't take it the first year; I was afraid I'd fail. But then I saw who passed the first year, and I figured, if they passed, I certainly could pass. (Laughter) I do standup comedy, too. I honestly don't know how I stand on this petition, as somebody who has been accused of teaching the ambulatory care version of inpatient medicine. When I teach inpatient medicine, a lot of it is focused on what's going to happen to the patient when they're discharged. We need to think of this as only one part of the care process. And I also teach am care rotations, too.

To me, fundamentally, you need the broad base that pharmacotherapy offers, especially if you're going to be an ambulatory care provider. You need to understand what went on in the hospital, because again, I struggle with, realistically, what's the best for our patients? And it comes down to continuity of care, and especially being BCPS certified, knowing the very broad range of care, and that includes when I'm in clinic as well.

Mark Israel: Mark Israel, BCPS. I'm actually one of the first pharmacists that took it. Thanks, Anne. New Jersey. It kills me to say this, but I really don't think ambulatory care would stand up to the specialized piece, as far as a specialty. It hurts being an ambulatory care provider for a long period of time, so, thank you.

Terry Schwinghammer: We certainly have plenty of time left. If anybody is sitting there holding something back, please let us hear from you.

Lisa McKee: Lisa McKee, Lebanon VA Medical Center in Pennsylvania. I guess my concern; I'm BCPS certified also. My concern is the fractioning of the whole pharmacy profession, making little units, separate entities that would make possibly the whole pharmacy practice a little weaker, just because we are divided. I mean, when I think about nuclear pharmacy certification, I know nothing about it. It's something that is completely a mystery to me, and so, there's a big rift between me and a nuclear pharmacist. And so, the more specialized or more fractioned that ambulatory care gets from pharmacotherapy, my fear would be that it would weaken the whole profession.

Gloria Grice: I'm Gloria Grice, I'm with St. Louis College of Pharmacy and I'm Board certified also. I'm actually undecided as to where I think the specialty may or may not go, but I have a question. I know you can't answer, but hopefully somebody in the audience can, about the history of these exams. I'm curious about oncology, since it came after pharmacotherapy. Prior to being its own specialty, were there oncology questions included in the pharmacotherapy exam?

Audience Response: Yes.

Audience Response: They still are.

Gloria Grice: Thank you. And there still are a few. Okay. So, my concern then with that is, will the pharmacotherapy exam, in the future, have a much smaller emphasis on a lot of the chronic disease state management, if this specialty becomes its own specialty? So, will we start to pull out more ambulatory care or chronic medication management issues from the pharmacotherapy, and if so, what will pharmacotherapy eventually be, or what will it look like? Will it be just acute care, or will it be more critical care? What will it do to the existing pharmacotherapy exam?

Also, on another note, as somebody who is Board certified in pharmacotherapy, I'm curious, if this does become a specialty, how many people feel similar to me, that now we have the option to get the second certification, will we do both, will we keep both, and maintain both? Certainly that's a lot of time and cost that's going to be involved in that. Or will we have to choose between either of the two, and how will we know which would be best? So, those are my concerns.

Terry Schwinghammer: Thank you, which reminds me. At the APhA meeting, we took a straw poll of those in the audience, since we realized that not everybody may speak up. If you don't mind, if I might just ask how many of you now are Board certified in one of the five existing specialties? If you wouldn't mind, raising your hand. It looks like the overwhelming majority.

And of those who are Board certified, put your hands up one more time, let me see if I can do this. Of those who have hands up and if you're BCPS certified, leave your hands up, and if you're not, put them down. Just only the BCPS people leave your hands up. That looks like- I didn't see any hands go down.

If this specialty were to be approved, how many of you BCPS certified would also go for the second certification in ambulatory care? I see 3 hands, out of 40 or 50 before. Okay, thank you.

The other thing we did was take a straw poll on those who currently, based on what you know today, are in favor of this new specialty. Those who are decidedly opposed to it, and those who are undecided at this time. So, if you care to vote, how many of you are in favor of the petition at this time? Please get your hands up, let me get a count here. About 10 in favor.

And how many opposed to the petition, based on what you know today? About 25.

And those who are undecided? About 18 or so, I didn't get an exact count, but that's good enough. Okay. Thank you.

Stuart Haines: Stuart Haines again, and speaking strictly on behalf of myself in this statement. One of the things that I personally struggled with, being a Board certified pharmacotherapy specialist, and joining in this petition is, its impact on the specialty I currently hold, and I think that's of concern to many people in the room. But, in looking at the definitions of the way we establish specialties in pharmacy, that's not the question we're asked to address, as to whether it would be good or bad for another specialty.

The question, as it was posed, and the way the petition process goes, is, is this a specialty in and of itself? And in that question, I believe we tried to make a case that in fact it is. I, like many in the room, share a concern as to what will be its impact on other specialties. I don't want to ignore that. It will have an impact, whether it will be negative or positive. In the end, I think, though, it creates an avenue for more people to become Board certified, and I think that's good for the profession. So, I hope, if this becomes a specialty, that people will be attracted to doing it, and becoming Board certified, because I think that's the end game - we have more people become specialists.

Mary Beth O'Connell: So since we have the luxury of having people who created this, can you give us your philosophy of why a specialty versus added qualifications? Because, although I took my vote, I'm still somewhat waffling in the middle, because of the large number of Board certified people and working in ambulatory care, I do see that there are some differences that would qualify for added qualifications.

Stuart Haines: This is not something that the group, the petitioners, specifically discussed, so I can only tell you what my philosophy would be, and anybody else who was part of the petitioners that would like to comment on it. One is, to earn added qualifications means that you already have to be BCPS which, for someone like me, would be a very attractive option. I would like to have added qualification as an ambulatory care specialist if it was recognized as a specialty area, but it does require someone to become BCPS in the first place. A separate specialty would allow people who, for whatever reasons, choose not to do BCPS, to have their own specialty. And our data shows, and we put it in the petition, there are many, many, many

practitioners who consider themselves specialists who simply will not go for BCPS. They just don't see it as representing their specialty area. And so, there are a lot of pharmacists who simply don't become specialists because they don't see their specialty represented.

So, added qualifications doesn't solve the problem of all those pharmacists who do not become Board certified.

Chris Papp: Chris Papp, Denver again. I still think that the pharmacotherapy specialty is not- The exam is not a data-driven, memorized, factual exam. It's about how you process information and make pharmaceutical decisions. Again, I practice in pediatrics, and I've found the exam very applicable to a completely different population, but the concepts, and it bothers me that people are shying away from the pharmacotherapy exam because it isn't specifically designed for their little niche, and I think you need to have an exam that does assess the broader skill sets for them to be certified. I strongly agree that added qualifications or additional qualifications would be the way to go here, and if you can't pass the pharmacotherapy specialty exam, then you probably shouldn't be certified.

Mort Goldman: Mort Goldman from the Cleveland Clinic. I think, looking at the specialties that are out there, maybe with the only exception of nuclear pharmacy, I think all of those specialties really ought to have a general, more general, BCPS certification prior to- I think oncology needs to be a subpart of pharmacotherapy. I think nutrition support needs to be part of pharmacotherapy. If you're going to have people making significant decisions on people's lives, just based on a small specialty area, they really should be generally Board certified in pharmacotherapy first.

And again, that just goes to Bill's discussion earlier about exactly what the criteria ought to be, to have a completely separate specialty in pharmacy, as opposed to having pharmacotherapy as the pharmacy specialty area, with either added qualifications or subtests that allow you to be certified in a specialty area. And I think am care follows that. I think there's a skill set in am care that is different than inpatient care, but the knowledge base, and a lot of the other pieces of it, are not different in any way, shape or form.

Bill Miller: Bill Miller again. I've heard a lot this afternoon about the need for more inclusiveness. Getting more people Board certified. Totally support that. But, I would look at medicine, for example, and their approach to specialization. I believe that we need to get it right. Get the conceptual framework right, and we started these things, we took what we had at the time, pharmacotherapy, it was broad. Oncology, I supported that. But I continue to be concerned that, if we go this route, we're going to end up, 20 years from now, trying to undo the configuration, because we didn't think it out. I think we've had enough experience in the profession with specialization, that we can figure this out. I would have preferred that approach first. I'm not convinced that am care does stand alone, because I believe the skill sets need to be both acute and ambulatory. At least, that's my view of the future of healthcare.

We do things at a particular point in time, that make a lot of sense, we have to revisit. I think the pharmacotherapy specialty should be revisited in some context. So, that's what's bothering me, is, we're just kind of ignoring what's already there and not rethinking how we want to do this. The sooner we develop that conceptual framework, then I'd like to see us move a lot faster than we're moving.

I know there are barriers financially to achieve this, and I think we need to look for creative ways to move much faster than we are. I think there are other areas. I'll mention one. Critical care pharmacy, and I know there's a group working on a paper that I've looked at. We're seeing hospitals now, because there's an insufficient number of pharmacists that are prepared as critical care pharmacists, that are taking individuals with one year of training and putting them in charge of a critical care pharmacy. Many of them do very well. They learn on the job. But I can think of any number of areas where there should be some certification, because we're certifying to the patients that they've had enough experience, and a lot of this has to do with repetition, to be qualified to direct the pharmacotherapy planning, which includes selecting drugs. We're at a higher cognitive level now than we were when this started. We were in a reactive mode, providing information.

Now what we see is what pharmacists are doing, largely, is being implemented. And I'm concerned, again, I've made this point several times, that we really need to pause, get this framework, and then move more rapidly. I would hope we'd have several whatever you want to

call them, added qualifications, subspecialties, in the next five years, and that this wouldn't be another ten year wait for further evolution.

Don Letendre: My name's Don Letendre, University of Iowa. I'd like to support what Bill was just saying, but I'd like to broaden it a bit, with a specific focus on residency training. I think that there's a huge disconnect right now, and continues to be a huge disconnect, between residency training and certification. And in advocating or supporting what Bill said, I think it would behoove the profession for us to take a step back.

As many of you know, I was on ASHP staff for 20 years, and responsible for residency training, and I recall all of the discussion and cussing and everything else that went around ambulatory care residencies as opposed to family medicine residencies as opposed to community care residencies, and fill in the blank residency. And I'm not sure we have it right, now, even in labeling it as a PGY 2 residency, I'm not sure, I'm not convinced that we've done the right thing.

I think Bill's right on target. I think it would behoove the profession for us to take a step back, which we don't typically do. We take a stand and we just move forward, as opposed to saying, okay, we didn't necessarily make a mistake, but at this particular junction in time, maybe this isn't the right thing for us to continue to do. It might be better for us to take a step back and work on Board certification in conjunction with residency training. Right now we continue to do those two things in isolation.

I wholeheartedly support what Anne was saying, as well, to look at this from a patient point of view. Not necessarily just from a therapeutic standpoint. But, what are we doing in terms of patient care, and how does this all intertwine? So, I would urge caution. Thank you.

Candice Garwood: Hi, I'm Candice Garwood and I'm from Wayne State University. In hearing all the comments today, I guess I'm in support of some of the concerns. I'm a director of a PGY 2 ambulatory care residency program, and, if this certification does indeed come about, I think that I'll have a very difficult time directing my ambulatory care residents as to which exam to sit for, pharmacotherapy or ambulatory care specialty. So that's just one thought that I have about this whole process.

Bill Miller: Since we're talking about residencies, I don't know the exact numbers, but we've had a large number of what were referred to as PGY 2 primary care, converted to ambulatory care, now being run as PGY 1 programs. A good part of this reflects that one can't get compensation through CMS for PGY 2 programs, but also, at least in my experience in talking to people as to why they've made this choice, it's been because people didn't feel they could recruit people into a PGY 2 am care program. And part of that, frankly, is because many people don't believe it takes a second year to practice in ambulatory care. That to me tells us something about the cognitive level required, and I think that's something you need to look at. What are we trying to accommodate, the current practices? We need to prepare people for not just current practice but future practices. So I think looking at residencies gives you a clue as to what Don was talking about, because we don't have any.

For Board certification, someone asked the question earlier. I will answer that question. Right now, if this goes through ambulatory care, then the ambulatory care programs, most likely the Commission would decide, to be an RPD, and that's where it is now. You'd have to be Board certified in that area. The problem with that is that we are not recognizing first year ambulatory care programs as specialized programs. We've seen, around the country, people who run the PGY 1's. They want to call them ambulatory care. They can't do that. That confuses the buyer. It confuses employers, and so forth. They can only call it a PGY 1 residency program. And so, there are some people who would like to have it both ways. So I think that's going to muddy up the water, as well, as far as where does this fit, and whether specialization's actually required. Just trends in the residencies that I think reflect some of the same concerns that some of us have.

Deanne Hall: Deanne Hall again, from the University of Pittsburgh, and just a comment, to follow up on the residency comment. A director of our PGY 2 ambulatory program, and having the original primary care program where we had to make the decision whether we wanted to go PGY 1 or PGY 2, which I thought was interesting, when that had come out that they actually let the programs choose which year we wanted to be. And we chose to be PGY 2 because we truly felt that, to be proficient ambulatory care practitioners, there were things that were not taught in a traditional PGY 1 pharmacy practice program, and again, becoming a specialist a lot is that repetition and being able to exert those skills, over and over again. So, we felt that we wanted our residents coming into our PGY 2 program to have that PGY 1 background.

That being said, one of the other comments about the difficulty in filling the positions, and we have had difficulty in filling our positions. We've only filled two over the past three years, and I filled this year with an early commit from our current program. And one of my concerns is, if we have another certification specialty exam, one of the things, especially in these budgetary times, is justifying keeping our residents financially, especially the second year residents, because we can't use a lot of that CMS funding.

So, I guess I'm kind of playing both sides of the fence here. I'm seeing some of our non-pharmacy administrators coming down and saying, 'Well, if these residents can get certified in ambulatory care, why do I need to have to pay to have a resident here for a second year?' So, I guess from a financial standpoint, I wonder whether this will help us or hurt us with the residencies.

Karen Sando: Hi. My name is Karen Sando, and I'm a pharmacy practice resident, the first year that mostly does ambulatory care. I'm from the University of Florida. In doing my residency, I do mostly everything outpatient, and I chose that because I knew I wanted to impact the chronic care of patients. I didn't really enjoy my inpatient rotation that much during school. And I chose not to do a second year because I felt I already had the exposure that I needed to be well involved in an ambulatory care setting.

It was interesting, when I was interviewing for jobs, and I got asked this question, about BCPS, and whether ambulatory care really is a different knowledge set, or whether its skills or what differentiates it. And the way that I answered it was, like the gentleman said, it's a decision-making process. I don't feel that the knowledge is really different. When I'm presented with a case, I have to use the same skills to be able to do it. But I think where it differentiates between am care and other specialties is the way that I get my patients to impact their own chronic health. And I'm not sure, as far as counseling and other methods that I use, I'm not sure if that really needs to be answered by a specialty exam, such as this. So, that's my comment.

Don Letendre: Another point that I failed to mention earlier that I wanted to just throw out for consideration. It doesn't speak specifically to this particular petition, but, perhaps helps us in our thinking more broadly. I think it's instructive for us to just go back and think about where we were in time when, for example, we established the whole BPS process, and bear in mind, that

when some of these things were under consideration, we were still dealing with residency training that had two different standards, the hospital residency standard and the clinical residency standard, and many of you in this room recall that. And then we moved towards developing a residency standard in pharmacy practice.

Well, I can share with you that when that happened, and I wrote that standard back in the 80's and when we started working towards BPS certification, not ever recognizing that I'd ever be back in academia, recognizing now that we are measured, as academicians, on the percentage of students that pass the State Boards. Well, why aren't our residencies measured on the number of residents that graduate and have to pass Board certification?

And so, I would throw out, for example, in my view, and of course, I thought I was going to be hung up by my thumbs when I made that recommendation, but thinking that perhaps, anybody that completed a pharmacy practice residency, as a measure of accreditation, should- Every one of those residents then, should complete Board certification in pharmacotherapy in my mind. I think that just makes good common sense, and I think that sets us on a path.

If we did something like that, then areas like ambulatory care and whatever the fill in the blank care again, go back to what Anne Hume was saying, let's just take a look at the whole continuity of care issue, then that becomes much simpler. Then if we think about laying on top of that, some of the subspecialty areas like cardiology, and nephrology and oncology and psych and whatever, in my mind, that becomes a bit more simple and much more logical.

So, I just offer those thoughts, and once again, supporting what Bill was saying, if we were to take an assertive approach, and step back, and now think about where we are today, as opposed to when some of these things were first put forward, and put forward in good faith with the information that we had at that point in time, I think perhaps we would make some different decisions today, and the linkage in my mind, between residencies and Board certification I think is imperative, as we go forward. Thank you.

Terry Schwinghammer: Last call? We do have about 14 minutes or so left in the schedule. Any last thoughts or comments? Hearing none, I think we'll call it to a close, and, on behalf of BPS

and the Board, thank you very much for an interesting, stimulating, enlightening conversation, and I look forward to the Board's discussions at our June meeting.

Thank you all very much for coming and sharing your thoughts. Enjoy the rest of the meeting. And please, again, send any written comments you have, by the end of May. Thank you.

END OF MEETING