

**BOARD OF PHARMACEUTICAL SPECIALTIES**  
**OPEN HEARING ON A NEW SPECIALTY IN**  
**AMBULATORY CARE PHARMACY PRACTICE**  
**APRIL 5, 2009 - SAN ANTONIO, TX**

Terry L. Schwinghammer: Good afternoon everyone. My name is Terry Schwinghammer. I'm the current Chair of the Board of Pharmaceutical Specialties. As you know, this is an open hearing where the profession can advise the Board of Pharmaceutical Specialties about the pending petition for the new Specialty in Ambulatory Care Pharmacy Practice. Joining me today on the podium are several other members of BPS and I'd like to ask them to introduce themselves briefly.

Jannet M. Carmichael: I'm the immediate past Chair of BPS, Jan Carmichael. I work at the Department of Veterans Affairs where I am the VISN 21 Pharmacy Executive, - the Western Region of the U.S.

Rebecca Finley: I'm Becky Finley and I am the Chair-Elect of BPS and I'm the Dean of the Jefferson School of Pharmacy in Philadelphia.

Dick R. Gourley: I'm Dick Gourley and I'm the APhA Board of Trustee Liaison to BPS and a former Chair of BPS and my day job is Dean of Pharmacy at the University of Tennessee.

Terry L. Schwinghammer: Thank you all. And my full time job is Chair of the Department of Clinical Pharmacy at the West Virginia University School of Pharmacy.

What we'll do here today, is I'll give a brief presentation on some background information followed then by an open microphone when you can offer your comments about the proposed petition for Ambulatory Care Pharmacy Practice. BPS has been certifying pharmacists in specialties for over 30 years. It was created really to respond to changes that were occurring in healthcare at that time that indicated a need to officially recognize areas of focus, knowledge and specialized practice and experience. Right now, as you probably know, there are almost 8,000 pharmacists who are certified and there are five different specialties. Nuclear pharmacy was the first in 1978.

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. The BPS board does take this mission very seriously as we consider BPS to be the pharmacy's premier agency for specialty certification in support of optimal patient care.

This slide outlines the history of Board Certification. As I mentioned, Nuclear Pharmacy was first in 1978, followed by Nutrition Support and Pharmacotherapy, then Psychiatric Pharmacy, and most recently, although it's been 12 or 13 years now since we've had a new specialty in pharmacy, Oncology Pharmacy practice in 1996.

This slide may also be familiar to many of you indicating the growth of pharmacy specialization since the year 2000 indicating, again, that there are approximately 8,000 pharmacists who are certified in one or more of the five different specialties. Note that the largest numbers and the greatest growth rate is in the Pharmacotherapy specialty practice. Some of the others started small and remain relatively small in comparison to Pharmacotherapy.

How then is a new specialty created? The BPS Board has a specific and formal method for developing a new specialty. And this process is detailed in what's called the Petitioner's Guide for Recognition of a Pharmacy Practice Specialty, which is available for download from the BPS web site, [bpsweb.org](http://bpsweb.org). In short, a petitioner needs to develop and document the case for a new specialty, addressing seven specific criteria, which we'll show you on the next slide.

Information must be presented to support and defend each one of these criteria.

As you may know, the Ambulatory Care Pharmacy Specialty including all its appendices is over a thousand pages in length. I'll talk more about the review process in the next few minutes, but the process is that after the BPS Board has received input from interested parties throughout the profession and other avenues and other experts, then the BPS Board makes a determination or decision as to whether to accept or reject the petition and therefore the new specialty.

This slide lists the seven criteria for specialty recognition that the petition must address. The first is public and pharmacy profession needs. That is, that the pharmacy profession and the public needs specialty trained practitioners in the area to improve the health and welfare of society. The services of the specialty practitioners cannot be provided by generalist

practitioners, or other healthcare professionals or by currently available specialties certified by BPS, and the petition must document that the public health and welfare are at risk without these specialized services.

The second is a clear and significant demand, that is the healthcare system and the public must have a demand for this. And demand can be defined as a willingness and ability to pay for the services of the specialty practitioners.

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

Criteria D and E are somewhat linked, that is that the practitioners in the specialty must have a specialized knowledge of pharmaceutical sciences that is also related to biological, physical and behavioral sciences, and the specialty cannot just be based on a practice environment or certain procedures or certain technical services that are provided. The knowledge also has to be different from that possessed by recent Doctor of Pharmacy graduates and it has to also be different from that possessed by other specialists certified by BPS.

Similarly, the knowledge and skills necessary to perform specialized functions have to be acquired through education and training beyond the basic level that recent Doctor of Pharmacy graduates have, and the specialized functions they perform must also be different from those performed by other Board Certified Practitioners.

Criteria D and E are largely defined through a role delineation or job task analysis survey or study that was performed for this specialty.

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

And, finally, there must be a method of transmission of knowledge about the specialty area through such mechanisms as books, journals, meetings, symposia, professional meetings and so forth.

How did we get to where we are today with this specific specialty petition? In line with its mission, the BPS Board has given a lot of thought over the last few years to the question, “Are we providing credentials that the pharmacy profession and the public need for both now and in the future?” Several years ago, as part of our strategic planning process, BPS discussed in detail what we saw as a significant potential interest in a specialty more focused on ambulatory care or primary care. And, clearly, we all know that that’s a growth area of healthcare and we were hearing both from BPS certificants as well as pharmacists who are not certified that ambulatory care could and perhaps should be an important addition to the list of specialties that BPS certifies. So we held focus groups at meetings of ACCP, APhA and ASHP to determine interest in this potential new specialty.

One clear message from all this is there really was not universal agreement about what this specialty would encompass, what it would involve and in fact, whether it was needed. And there was not even agreement among the BPS Board about these particular issues.

For that reason, we did something that was really new for us and that is for BPS to conduct the initial role delineation study or the job task analysis to bring some definition to what ambulatory care (or what some were calling primary care) practice was. The goal was to determine what the domains of that practice are and what the associated tasks would be and what the associated knowledge statements would be in such a credential. BPS convened a task force of knowledgeable people to work with a psychometric consultant to carry out the study. And some of you may have participated in that role delineation study. That report was released to the profession in July of 2007.

Now, although BPS doing the role delineation study was not how the other BPS specialties started - those role delineation studies were done by the petitioners - that was a logical step in this case and a perfectly certainly legal step for BPS to take, permitted by the specialty recognition process. We really saw that as just an expedient way to get to really focus in on a discussion that was already ongoing and to provide a good set of parameters around the proposed specialty.

Once that role delineation study report was released, BPS stepped back and let the profession decide then whether one or more groups was interested in picking up the ball and running with it

to develop a petition in line with our formal petitioning process. So now, that's where we are today. ACCP, APhA and ASHP have jointly developed this petition to recognize Ambulatory Care Pharmacy Practice. That petition was delivered to BPS in November of 2008.

So now, we're at the next stage of the evaluative process and that is gaining information from you all, from the profession of pharmacy and the public that help advise BPS, on our course of action with respect to this specialty. It's important to note that BPS has not made a decision. We have not made up our minds for or against this specialty, in fact, have not really discussed in detail whether an Ambulatory Care Specialty would be successful, would be approved, or is needed.

To summarize this process, when a petition is received by BPS, it's initially reviewed by BPS staff to make sure that it is complete and they have addressed all of the criteria. If that is met, we are ready to receive input from across the profession. This is the second of three such open hearings that have been scheduled. The first was at the ASHP mid-year in Orlando last December, and the third one will follow this meeting at the ACCP spring forum later in April in Orlando.

With hearings at all three of the organizations that sponsored or developed the petition, in addition to accepting written comments, we hope at BPS that we'll be able to gain a good view of how the profession feels about this new specialty. We do hope to have all of the input and information necessary for the Board to make a decision during the first half of this year. We have a Board meeting scheduled for June, in fact, and we hope to make a decision at that point.

The goal at this meeting today is to generate information that will be useful to the BPS Board when the Board is called on to decide whether Ambulatory Care Pharmacy Practice should be approved as a specialty or not be approved. Any member of the audience is entitled to speak and we hope that you will, either for or against the petition and the proposed new specialty.

Because we need to develop a verbatim transcript of the hearing, we ask that all speakers please step up and use the microphone in the room and wait to be recognized to speak. First, please state your name and identify your affiliations, where you're from and any other background context for your remarks.

Deborah or Jackie, of the BPS staff, would like to write down your name and affiliation so we have spellings correct, so please be sure to see them before or after you speak.

We will try to take speakers in order and we won't try to alternate pro versus con statements, we'll just take you all as you come. As a speaker it is fair to react to a previous speaker's comment if you would like.

The other BPS Board members and I are here to listen to your input; that's our only job. As I mentioned, we have not in any way made up our minds about this specialty and we will not be providing any opinions about the specialty. That's not our function today. Our function is to obtain information from you that will help us make a well-informed judgment about the specialty.

We also will not be providing any information about the petition itself or about the content of the position. As I mentioned, it's been released and widely available to the profession and we hope that people commenting on the petition are well versed in its content.

Our time is scheduled to go to 4:30 pm if there are enough commenters to warrant that time, otherwise, we'll end it when there are no more speakers left or there's nobody left in the room except for the Board members.

There is no specific time limit for a given speaker. But, of course, be courteous if you see others are waiting, to not monopolize the time. You may also submit written comments to the mail or e-mail addresses on this slide. So if we run out of time before you get a chance to speak, you may submit comments by mail. Also remember, that we will have the third open hearing at the ACCP meeting in Orlando later this month. BPS will continue to receive comments through the month of May, which is just next month, so please make sure that you submit all your comments by the end of May.

With that, we will open the microphones for your comments and in advance, we thank you all very much for assisting BPS in this very important process.

John Feather: Good afternoon. Thank you for having us. My name is John Feather, I'm the Executive Director of the American Society of Consultant Pharmacists and I'm also the Interim

Director of the Commission for Certification in Geriatric Pharmacy. We did submit comments to you in writing and I will share another copy later today to make sure that they're in the record. I am making this presentation on behalf of the Chair of the Board of CCGP, Jane Huff and Dr. Judith Beizer, who's President of ASCP, and please excuse me for reading parts of this to you, but I just want to make sure that we are consistent in our testimony to you.

As you know, CCGP, which is an affiliated organization with ASCP, offers the certified geriatric pharmacist credential. Since 1997, 2,300 pharmacists have taken this exam and been certified and it looks at the specific competencies in geriatric pharmacotherapy principles and the candidates' ability to provide pharmaceutical care to the elderly. This approach is, from our standpoint, different in both the philosophy and the practice from the tradition of specialty certification for specific disease states, such as oncology or certain kinds of clinical care, such as nutrition support or nuclear pharmacy. Geriatrics focuses on treating the whole patient rather than specific diseases. There are inherent principles unique to the elderly patient that may well include pharmacokinetics, pharmacodynamics and social aspects as well as physical and financial access to care and adherence.

In addition, the geriatric patient is rarely being treated for one condition alone; most are being treated for comorbid physical conditions, often in addition to cognitive deficits. So we think that the practice of geriatric pharmaceutical care is in some ways distinct and, therefore, we do applaud BPS and the petitioning organizations for the attempt to continue to foster excellence in pharmaceutical practice through certification and, obviously, we share your commitment to wanting to make sure that we have additional qualifications post licensure for people that are working in specialty areas.

One of the things that struck us was that the petition does not use the terms geriatrics, older adults, or aging. However, the emphasis of the program will be and these are all quotations, "patients with complex disease, problems and medication regimens", "ambulatory patients who have multiple coexisting conditions", "complex ambulatory patients with chronic diseases", and "chronic and preventive care patients." Certainly, chronic conditions can occur at any age, but the large majority of the ambulatory patients that would fit under these definitions are older adults who need the special skills of geriatric management. The pharmacist may be

knowledgeable about the principles of pharmaceutical care or disease management, but the application of this knowledge to an older adult requires a different set of skills and knowledge that may go beyond the management of individual diseases.

With that in mind, our request from CCGP and ASCP is to respectfully ask that BPS consider the following questions before approving a new certification. So, we're not taking a pro or con position at this point. The first question is how will patient populations for this certification be defined and will the majority of that population be older persons? If so, how will the principles and practice of geriatric care be included in the certification process?

How will this new credential complement the certified geriatric pharmacist credential?

How will this new certification be communicated to the population that it is intended to serve?

And how does this certification advance the profession in a way that consumers, caregivers and purchasers of healthcare will understand its value? We look forward to working with you and we applaud your efforts in quality pharmaceutical care. Thanks.

Dick R. Gourley: Could we get a copy of your comments? Thank you.

Nan Davis: My name is Nan Davis. I still work part time in a hospital pharmacy. I'm certified as a consultant pharmacist in New Jersey, but most of my consulting is with addiction, halfway houses, and input into treatment facilities, and some of us in recovery do continue that way. I live in a retirement home, so I'm familiar with that. I was one of the founding members of the Addiction Pharmacist Interest Group in APhA. I'm also a member of ASHP and I noticed that Jann Skelton was one of the writers of this and I contacted her and she said if the addiction people thought it was a good idea, I should come and make positive comment.

We had hoped, because we had help in developing the University of Utah's School of Alcohol Studies for students and pharmacists, that we would have a specialty one day similar to the American Society of Addiction Medicine. This has not happened. Some of us feel that this specialty could include our lifetime, lifelong disease among the chronic diseases, although many, of course, as we age have many others as well, but that this would be a possibility.

And our hope is that those who would serve in addiction or in ambulatory care would have the skills to help with this and since it's estimated that we are 11 to 20% of the population and that we tend to be a high risk gene pool whose children need to be raised with many less drugs than are advertised on television, that this would be, this has the potential to be positive. We did not write all this out. I have an article here that has been published in a journal. Thank you.

And I'm sorry, I have to leave, but one of our major presentations on pharmacists who suffer from the disease is happening at 3:30. So thank you.

Terry L. Schwinghammer: Thank you, Nan.

Don't be bashful. I was going to ask if there are some present who helped prepare the petition for one of the petitioning organizations, who would like to say anything in support of the petition or provide background additional information or clarifying information that might be helpful for the group. Please step up.

Patty Kumbera: My name is Patty Kumbera and I am one of the cofounders and principals of Outcomes Pharmaceutical Health Care. We are an MTM administrator and pay pharmacists throughout the country for MTM services on behalf of multiple different types of payors.

I rise to tell you my initial reaction when I heard about this and to share that we are paying thousands of pharmacists around the country right now, and when I looked at the background, kind of supporting the petition for it in the first place, and it indicated that perhaps, around scope of services, and I think we already have barriers within our profession around scope of practice. Others outside of our profession already kind of try to limit us and I feel that there were statements, even in the background, that made it sound like some of the services we're paying for actively every day today, are services that any pharmacist anywhere who is licensed, can provide. And I think that concerns me a little bit to start poking holes into what somebody with this particular specialization could do, that it might be out of the normal scope of services. So, I bring up that point.

There are a lot of programs out there that are paying pharmacists, and many of them put a lot of barriers on the front side in order to require pharmacists to do certain things in order to be able to even deliver any services. There's really two sides of that. Some believe in putting barriers on

the front side, and what the kind of end result is, is not great uptake in adoption and pharmacists doing it. Others kind of take another approach, like we have. We make entry easier and have quality assurance processes on the back side to try to improve and measure quality to make sure the services are appropriate for the patients.

So, I just rise with caution because, to me, it seems like it's another area of segregation within our profession, it's almost by location more than it is by a specialty area like oncology and it's more like by where you're practicing as opposed to the services around that. I made some notes, but I may rise again, if others keep chiming in on this.

But anyway, I rise in caution to the notion because, even though it's a voluntary thing right now, in a world where I think MTM is going to exponentially change in the next 12 months with the new CMS 2010 changes for next year, I think it could become a reason why payors will point to it and say, "Well we'll only do it if people get this special accreditation". And that will become another reason why not to pay for these things, because there will be a barrier there and a lot of pharmacists won't do it. All right?

Terry L. Schwinghammer: Thank you. Stuart.

Stuart Haines: Stuart Haines from the University of Maryland, and as one of the writers on the petition and one of the petitioning organizations, obviously, I speak on behalf of the petition. We put forward the petition with the hope that BPS would recognize Ambulatory Care as a specialty. But I do want to let folks in the audience, as well as BPS, know that there was a significant amount of debate about what the title of the petition should be. Whether it should be Ambulatory Care, which would imply a setting, which is not our intent. We chose the title "Ambulatory Care Specialty Practice," because it aligned with what is the current terminology for PGY2 Residency Training and we're not tied to that specific titling of the specialty. So Ambulatory Care is not intended to imply a setting of care but rather, as the petition lays out, a practice style, and we did provide a definition for what Ambulatory Care Pharmacy Practice is, that is in the petition.

Loni Garcia: I am Loni Garcia, I'm a community pharmacist. I'm a BS Pharmacist who did a master's and two year residency, which allowed us to tailor our residency as to our special

interest. Mine was Ambulatory Care. So I was thrilled when I saw that a petition had been submitted. I'm now in what many people would refer to as a chain pharmacy setting. So my comment is this. Please be cautious, if you choose to go forward with this certification, that you do not exclude some of our chain pharmacists and independent pharmacy owners, who aren't in what I used to think of as an Ambulatory Care setting. I thought of a clinic or a multidisciplinary practice setting. But there are pharmacists out there that are doing tremendous patient care and would deserve to have an opportunity to become, to document or to prove their competency, as an Ambulatory Care specialist. Some of the people that this lady is actually talking about, who are doing the MTM, but that's just, don't forget those folks.

Kelly Goode: Kelly Goode, I am a community pharmacy faculty member at Virginia Commonwealth University, and a petitioner from APhA. I just want to reiterate that, if you read the definition of Ambulatory Care, it's not a practice setting, so it would be open to community pharmacists, whether you're a chain pharmacist, an independent pharmacist. As long as you're providing the type of care that meets the criteria of Ambulatory Care as we relate it. And it's not just geriatric care of patients, it's across the lifespan in prevention, wellness, coordination of care, for patients. So, it's really the Ambulatory Care style. It's not a setting, it's not a clinic. We struggled a lot with what to call this petition. BPS, if they decide to go forward, may not call it Ambulatory Care, it may be something totally different. But it's a style of practice and a continuity of care of patients across the lifespan, prevention, wellness, chronic disease, etc. And I have the definition, if you'd like to see it, if not it is also on the BPS website with the petition.

Terry L. Schwinghammer: Thanks, Kelly.

Janet Silvester: I have to say something. I'm Janet Silvester and I am the ASHP immediate Past President. And I guess one perspective I'd like to share is, as you look at what's happening in our country, we're seeing logarithmic growth in our population, especially our elderly population, and we are going to face a deficit in Primary Care practitioners in the very near future, and we are as close as we've ever been to the reality of healthcare reform. So I think that we're at a perfect place, actually, for pharmacists to establish themselves as exceptional practitioners in this specific area of practice and I think we have a role to play. We have a big need that we can help fill, and I am absolutely in support of this petition.

Terry L. Schwinghammer: While we still have a good number of people here, it was suggested to me, this might be interesting; I don't think this is part of our normal procedure, but we assume that you all are here because you have some interest, at least, in Ambulatory Care Specialty Practice. And we thought maybe it might be interesting to do sort of a straw poll to see where you stand on this today for, maybe as much for our benefit as anything, but maybe for each of your benefit as well. So, I guess what I'll do, is ask whether you're, based on what you know today, whether you're in favor of the petition, whether you're against the petition, or whether you're undecided at this point. Is that a fair thing?

Speaker: Yeah.

Terry L. Schwinghammer: Okay. So I'm going to ask everybody to close your eyes, no we won't do that. No, you can if you want, but I'm not going to. So if you're, right now, based on what you know, realizing that your position could change based on more information, if you're in favor of the petition as of today, clearly in favor of it, if you would just indicate by raising your hand. Wow. Pretty good number. I don't know if anybody's doing a count but hold them up for just a minute. Got a pretty estimate.

Speaker: Thirty eight, thirty nine.

Terry L. Schwinghammer: Those you who now are, at this point, are clearly against this petition, similar, same sign please? If you're against the petition. I don't see any, do you? Those then who are ambivalent or undetermined, undecided at this point?

Speaker: Eighteen.

Speaker: Nineteen.

Terry L. Schwinghammer: Okay. Thank you, that's helpful information.

Speaker: Thirty eight to nineteen, 38, 0, 19, something like that.

Terry L. Schwinghammer: So it's about two in favor, to 1 undecided to none really opposed, definitely opposed at least.

Rebecca Finley: How about another straw poll. How many of you consider yourself to be Ambulatory Care Practitioners?

Terry L. Schwinghammer: Wow!

Rebecca Finley: Well. Whatever you think you are. Okay. Keep your hand up. Okay. Thank you.

Terry L. Schwinghammer: Patty.

Patty Kumbera: I'm curious, can I ask for my own straw poll?

Terry L. Schwinghammer: Sure. Please come to the microphone so we'll be sure to get it on the transcription. Thank you, Patty.

Patty Kumbera: I guess I'd like to poll to know, how many are pharmacists vs. students vs. other?

Terry L. Schwinghammer: Okay. So let's start with Pharmacists, how many of you out there are already Pharmacists? The vast majority it looks like. So, yeah, it would be easier to ask then, how many are students? How many students do we have in the audience? I see one maybe, maybe one.

Speaker: How many are not Pharmacists at all?

Terry L. Schwinghammer: Are there others that are not pharmacists or pharmacy students? Jonathan. Jackie. Okay, some staff. Thank you.

Tony Provenzano: Hi, Tony Provenzano, Director of Clinical Services for Supervalu. I just want to echo a little bit more about the caution of doing this, just from experience and from our area where we're working really hard, as a chain pharmacy, to try to get more payors and more opportunities for pharmacists to provide clinical services, especially MTM. And it's hard enough today to get pharmacists to accept that they can do this and then get them trained and do it. And we have a bunch of pharmacists in our company that are doing MTM and other clinical services and doing an outstanding job at it. And I have a little bit of caution, that this again, will

help; it might give the appearance of a differentiation. Like they may not be able to do that, so an internal feeling, or prevent some people from moving forward to try to do more clinical services, unless they have an additional degree. And I think so many pharmacists are capable of doing this already and this might be a discouraging factor for them to go ahead, depending on all the barriers and whatever has to go through to get this.

And I do share a caution, that payors out there may either use this as a reason not to pay pharmacists and say, only if you have the certification or, through lack of education, not have a clear understanding that more pharmacists can do this thing, and just do it out of lack of education or just out of sheer reasons not to pay. So I just, again, echo Patty's cautions on this. I think, in general the idea is good, but I think there's a lot of other things out there we have to consider.

Carlisha Colbert: Hello, my name is Carlisha Colbert, I'm a community pharmacy resident with East Marietta Drugs, which is part of Mercer University. And I just had a question; I forgot the gentleman, oh he's here, but in regards to differentiating or having that caution, how is it differentiating from, okay you have AM Care and people may not pay for that, but then you do also have BCPS or you even have CGP. Are you seeing a difference in people being willing to pay for that through MTM services, or is it just because you feel there's a differentiation with AM Care, then they'll expect all pharmacists to have that?

Tony Provenzano: No, you can stay. My experience comes, just as an example in the area of diabetes care, where we started out in our clinical services with diabetes care, and we had payors, several of them say you have to be a CDE or we won't pay you, even though our pharmacists are very well trained and can handle, in the scope of what we're looking to do, can very well handle that. And then there was the CDM, when the CDM came out. CDM was a little bit different. It was more obtainable and, again, I'm not sure how this process will be compared to a CDM-type of a certification, but we had payors that came out and demanded that you had to be a CDM to do that. Which again, just gave more barriers, more reasons for pharmacists to say, I'm not sure I can do that, and made it more challenging.

Edwin Webb: I'm Ed Webb with the staff of the American College of Clinical Pharmacy and part of the petitioning group. And I would acknowledge, and I think we should be cautious, with

regard to the issue that Patty and Tony have raised. I think that's entirely appropriate. But I think on the other side, there's an obligation, on the part of the profession, to help the payor community understand some of these distinctions and how they relate to quality.

I think it's important to remember that, at this stage and for as far as we can see into the future, board certification, as a specialist in pharmacy, is an entirely voluntary process through which people can go to demonstrate additional knowledge and skillsets in the specialized area of knowledge and training. And it is incumbent on the profession, I believe, to let the rest of the healthcare system know that there are areas of specialized care in pharmacy that deserve credentialing. And we believe that it's time for the profession, and the stage we're at is, we're asking the profession to speak in response to a petition that has been submitted to try to make the case that this, in fact, is a specialty.

If it turns out not to be, if the profession doesn't believe it is or if BPS believes it's not, then so be it. But we have an obligation to raise these questions, it seems to me, to the rest of the healthcare system, so that they can understand where it is that the profession is going. And so I just would encourage folks, and I just would encourage people, if you haven't looked at the petition, don't be overwhelmed by the 1,000 pages. You can get most of it in the Executive Summary and you can certainly get it in the 97 pages of the actual petition and not the 1,000 pages of supporting appendices. So, read the petition, understand it, and let BPS know what you think about it.

But I think, overall, we now have almost 6,000 board certified pharmacotherapists in the United States. They are practicing in a variety of settings: ambulatory care, inpatient care, specialized care. They have been able to demonstrate a level and scope of service that is being increasingly embraced by the healthcare practice settings in which they practice. They have demonstrated that pharmacists can bring unique and specialized knowledge and skillsets to the care of patients. We just need to figure out, as a profession, whether this area of practice is sufficiently specialized in what we do, to achieve specialty recognition. And that's why we're here to discuss it and debate it, and hopefully, come to a resolution on it.

So that, if it is, in fact, a specialty, we can begin to put together a process, that BPS can put a process together, that will examine this and give credibility to it, so that the rest of the healthcare delivery system can actually embrace it and understand it.

Kelly Brock: My name is Kelly Brock, and I'm actually an independent consultant now, but my background is community practice. And I can echo the current concerns that I'm hearing; I remember having these feelings myself. And then I was actually asked to sit on the task force that did the role delineation study and looked at the domains of practice because, you know, one of my initial concerns was, do we want to put more barriers in place for us to be compensated for what we do? But then, as I thought about it and as I met with this fascinating group of practitioners that came together to look at the domains of practice, when we looked at it, we thought right now, that could occur because we already have a board certification in pharmacotherapy. So if they want to do that, if they want to put those barriers in place, they can do that to us in our specialty and ambulatory care.

However, as I went through the process and we looked at all the domains of practice and all of the tasks and the skills that we have in this specialty which includes community practice, it was amazing to me, all of the things that we do. And the things that we do that are different. And so it was a very eye opening experience for me to really think about that, I can understand the concern, however, I think it could already be there. So, if they're going to go ahead and use a barrier to stop us from getting paid for services, then at least let's have a certification that talks about the specific area of practice that we are in and that we are specialists in.

And so I really, I just kind of want to emphasize that we spent a weekend, very long, long days, however, they were very good days, but they were very long days, thinking through this process. And I can tell you, we had a lot of discussions, a lot of heated debates, very healthy debates, but we had a lot of people around the table. We had people from primary care settings, ambulatory care settings, community practice, which we all kind of now fall into this same category, but everyone shared their experiences, and we really did decide that we felt, very strongly, that we do have very significant differences than the current specialties that are out there.

So I speak very passionately for the specialty, but just wanted to share that with you.

Terry L. Schwinghammer: I'm sort of feeling maybe like you, that are we at the end of the time? Certainly, I don't want to cut off time prematurely and I would like to encourage anyone who has the slightest bit of reticence about standing up, to please feel free to make your comments known. That's really what we're here for, so please take advantage of the opportunity while we have plenty of time left. Or if you have a straw poll you want to conduct?

Mark Walberg: Hi. I'm Mark Walberg, Faculty at the University of the Pacific in California. I'm also a community pharmacist and member of a Part D Medicare Outreach Program. We're actually, I guess, a different kind of ambulatory care pharmacist in that we walk to the patients, because a lot of our patients are in Assisted Living facilities, HUD housing, that sort of thing. And I think I was back there trying to scroll through the 96 pages of the petition to look for this on my I-Phone, which wasn't very successful.

But one of the issues that we come up with, and I couldn't find this in the Executive Summary or in the 96 pages of the petition, but one of the major things we deal with isn't the actual medications but it's the cost, the acquisition, and those issues that surround medication use, more so than even guideline concordant therapy in many of our patients. So, while that is a big issue, making sure they're on the right meds, making sure they can afford their meds and that you can work with the patient to do that, I think, is a major issue that, if we're going to look at Ambulatory Care, I think cost needs to be a big part of that. Thank you.

Kelly Goode: I'll just respond to that, Kelly Goode, I'm one of the petitioners. Yes, access is part of that partnership with patients, patient advocacy, all falls under a domain of this specialty, so it is incorporated in there.

Carlisha Colbert: Again, Carlisha Colbert, I'm a Community Pharmacy Resident with Mercer University. I just wanted to comment that I didn't say this earlier, but I'm very much for the specialty with Am Care. And just to kind of give a little background about me, I'm actually studying with some fellow colleagues that are actually within the Am Patient Care realm of Pharmacy and studying for BCPS. And I was currently studying with them, and when I look at the Am Care Section, I guess that's through ACCP, for the study guides and everything, I looked at the component of Am Care and it was very very short, but I felt there is so much more to Am

Care, which I haven't had an opportunity to read through all of the petition, but there's so much more to Am Care that could definitely be fulfilled in that section.

In looking into BCPS for the Pharmacotherapy Specialty, I felt that was the only option I had, if I definitely wanted to further specialize in those services. But, I felt along with myself and some of my other colleagues, that the Ambulatory Care Specialty would give us another option as to what we more so focus in as opposed to just doing the specialty for Pharmacotherapy.

Terry Schwinghammer: Last call. Before we do wind up, I want to remind folks, as I said at the beginning, that BPS is still taking and will take comments through mail or e-mail or telephone if you like, through May; e-mail address is on the slide, and we hope to make a decision sometime in June, I think, this year.

If there are no further comments or questions, we thank you all for coming and spending an hour or so with us today and for giving input to the board on this petition for a New Ambulatory Care Specialty.

Thank you all very much and enjoy the rest of the meeting.

**END OF MEETING**