accp Report

American College of Clinical Pharmacy

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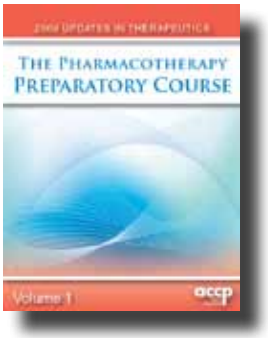
2009 Pharmacotherapy Preparatory Course Instructional Materials Now Available

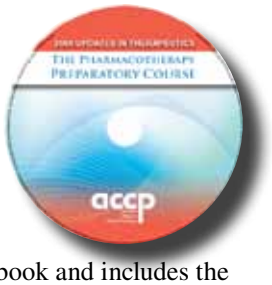
Instructional materials are now available for the 2009 edition of *Updates in Therapeutics: The Pharmacotherapy Preparatory Course,* the same course that was presented live at the 2009 ACCP/ESCP International Congress on Clinical Pharmacy.



Updates in Therapeutics: The Pharmacotherapy Preparatory Course is ideal for pharmacy professionals who are preparing for the Pharmacotherapy Specialty Certification Examination administered by the Board of Pharmaceutical Specialties and for those seeking a self-paced review and refresher of disease states and therapeutics. Developed by board-certified pharmacotherapy specialists, the course content provides a comprehensive review of the knowledge domains covered in the Pharmacotherapy Specialty Certification Examination. The course uses a case-based approach, with strong emphasis on the thought processes needed to solve patient care problems in each therapeutic area.

Course materials are presented in a variety of formats to suit different learning styles. Continuing pharmacy education credit is available through successful completion of online post-tests. The maximum number of continuing pharmacy education credits available for the preparatory course is 22.5 hours. Instructional materials are available in the following formats:

- **Course workbook.** Presenter handouts are provided in a spiral-bound book. These materials include case studies, study questions with answer explanations, and literature citations for further reference.
- **Online book.** Information contained in the printed course workbook is also available in this online version. The online book provides access to course workbook contents as Portable Document Format (PDF) files.
- **CD-ROM.** The CD-ROM includes the presenters' lectures, which are audio-synchronized to the slide presentations from the live program. The CD-ROM is both PC and Macintosh compatible and contains MP3 files of the presenters' lectures. (The CD-ROM is not CD-Audio compatible.)
- **CD-ROM and Course Workbook with CE.** This package includes the full course workbook and a CD-ROM, plus access to the Web-based post-tests for continuing pharmacy education credit.



- **Web-based Online Course with CE.** This combination provides participants with the online workbook and includes the presenters' lectures, which are audio-synchronized to the slide presentations from the live program. The online course additionally provides participants access to the Web-based post-tests for continuing pharmacy education credit.
- **CD-ROM and Online Workbook with CE.** This package includes the CD-ROM and full course online workbook, plus access to the Web-based post-tests for continuing pharmacy education credit.

Instructional components also are priced for individual sale. Orders for Pharmacotherapy Preparatory Course instructional materials may be placed online at *http://www.accp.com/bookstore/ppc09.aspx*. Orders may also be placed by phone at (913) 492-3311, or by fax at (913) 492-0088.

Prices	Member	Nonmember
Print Workbook and CD-ROM with CE Credit	$340.00	$480.00
Online Workbook and CD-ROM with CE Credit	$325.00	$465.00
Online Course with CE Credit	$305.00	$445.00
CD-ROM	$210.00	$315.00
Print Workbook	$145.00	$210.00
Online Workbook	$135.00	$200.00

The American College of Clinical Pharmacy is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. The Universal Program Numbers are:

- 2009 Pharmacotherapy Preparatory Course: Pediatrics, Geriatrics, and Oncology Supportive Care. Program No. 217-000-09-013-H01-P; 3.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Biostatistics: A Refresher and Clinical Trials: Fundamentals of Design and Interpretation. Program No. 217-000-09-014-H01-P; 3.0 contact hours.

- 2009 Pharmacotherapy Preparatory Course: Infectious Diseases, HIV/Infectious Diseases and Pharmacokinetics: A Refresher. Program No. 217-000-09-015-H01-P; 3.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Neurology and General Psychiatry. Program No. 217-000-09-016-H01-P; 2.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Acute Care Cardiology and Critical Care. Program No. 217-000-09-017-H01-P; 3.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Nephrology, Endocrine and Metabolic Disorders and Fluids, Electrolytes and Nutrition. Program No. 217-000-09-018-H01-P; 3.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Ambulatory Care; and Men's and Women's Health. Program No. 217-000-09-019-H01-P; 3.0 contact hours.
- 2009 Pharmacotherapy Preparatory Course: Gastrointestinal Disorders and Outpatient Cardiology. Program No. 217-000-09-020-H01-P; 2.5 contact hours.

To receive continuing education credit, the Web-based post-test must be successfully completed and submitted to ACCP by October 31, 2010. Statements of credit for continuing pharmacy education will be available to participants within 6 weeks of successful completion of the Web-based post-test at www.accp.com/ce. Learning objectives, faculty disclosures, target audience, program goals, technical requirements, and samples of the 2009 Pharmacotherapy Preparatory Course are available at http://www.accp.com/bookstore/ppc09.aspx.

bps Board of Pharmaceutical Specialties

BPS Application Deadline Is Approaching

Pharmacists are reminded that August 1 is the deadline for submitting applications to take the Board of Pharmaceutical Specialties exams in Nuclear Pharmacy, Nutrition Support Pharmacy, Oncology Pharmacy, Pharmacotherapy, and Psychiatric Pharmacy. This year's exams will be administered on Saturday, October 3, at several sites in the United States and worldwide.

The new BPS Web site at www.bpsweb.org provides an easy online application and payment process for first-time exam candidates.

The number of pharmacists certified by BPS continues to grow—with nearly 8000 at last count. Many employers pay for the exams or provide bonus pay for BPS-certified specialists, and many of these pharmacists report that their certification is counted in promotion and clinical privileging decisions affecting their careers. Specialty certification is a great way for a pharmacist to distinguish himself or herself in practice. Don't put it off any longer!

ACCP PBRN Registry: A Cross Section of the Membership

To date (as of May 28, 2009), there are 359 individual members. ACCP PBRN pharmacists provide clinical services an average of 5 half-days (±3 days) per week. This represents a total of 1165 half-days/week. For the 356 who see patients, the mean number of patients seen by our PBRN members each week is 45 ± 50 (0–200). This equates to 9120 patient encounters by our PBRN clinical pharmacist members in 1 week. Only 9% have any dispensing activities. Of those, the average is 11 hours/week spent dispensing. About 38% use scope of practice agreements. Virtually all of the PRNs are represented. The ACCP PBRN membership reflects a true cross section of the ACCP membership.

A total of 207 sites are registered in 43 states and 11 countries. About 61% of our ACCP PBRN members practice within an inpatient or emergency department setting, and the rest practice in an outpatient setting. Ninety percent are located in urban areas with populations greater than 50,000. Almost two-thirds use electronic medical records, and virtually all (93%) have Internet and e-mail capabilities.

The ACCP PBRN registry is open to all ACCP members who are involved in direct patient care or have access to patients for research purposes. No research experience is required. Join the registry today at *http://www.accpri.org/pbrn/registration.aspx*.

New ACCP Chapter Established in Saudi Arabia

The ACCP Board of Regents recently approved unanimously the application for ACCP's newest chapter, the Gulf College of Clinical Pharmacy. ACCP's 17th active chapter serves pharmacists in the countries of the Kingdom of Saudi Arabia, Bahrain, United Arab Emirates, Qatar, Yemen, and Iraq. The chapter's founding president is Mr. Hamad M. Al-Dhewalia, its president elect is Mr. Saud A. Al-Abdulmohsin, and its secretary is Dr. Jean Dib, all from Dhahran, Saudi Arabia.

In discussing the need for this chapter and its goals, Dr. Dib commented,

> The idea of establishing an ACCP chapter in the region came after recognizing the need for such an organization to expand the practice of clinical pharmacy. The chapter will provide pharmacists with leadership, education, advocacy, and resources enabling them to achieve excellence in pharmacy practice. The idea was shared and supported by a large number of clinical pharmacists who revealed their excitement and willingness to join this chapter to serve the profession in the region. The Gulf College of Clinical Pharmacy was formed as an active chapter of the ACCP and, as such, also supports the mission and goals of our parent organization. This is the second ACCP chapter established outside the United States that serves the Gulf area. One of our chapter's goals is to advance human health and quality of life by helping pharmacy practitioners and educators to expand, support, and enhance direct patient care practice in the region through support and promotion of research, training, and educational programs; and disseminating scientific and professional information and knowledge about advances in pharmacotherapy. Currently, the chapter consists of approximately 40 members and is growing. Several activities have been planned for this year such as educational seminars, networking meetings, and other local pharmacy-related events.

For more information about the Gulf chapter or to become a member, contact Jean Dib at jean.dib@aramco.com.

Washington Report

John McGlew
Associate Director,
Government Affairs

The Obama administration, still less than 200 days old, is moving ahead with its ambitious proposal to succeed where the Carter and Clinton administrations failed and deliver meaningful health care reform.

Undoubtedly, some factors appear to favor the President. According to opinion polls, 72% of those questioned favor increasing the federal government's influence on the country's health care system in an attempt to lower costs and provide health care coverage to more Americans, with just 27% opposing such a move.[1]

The global financial crisis has underscored the extent to which the burden of health care costs threatens the viability of American manufacturing and the challenge that the burden of health care costs places on the American entrepreneurial spirit. According to GM, health care costs add $1525 to the price of every General Motors vehicle. The company spent $4.6 billion on health care in 2007, more than the cost of steel.[2]

Nationally, the United States spent around $2.2 trillion on health care in 2007, or $7421 per person. This comes to 16.2% of the GDP, nearly twice the average of other developed nations. Yet the United States lags behind other industrialized nations – ranked 47th in life expectancy and 43rd in child mortality.[3]

Politically, proponents of health care reform appear to have the muscle they need to push this through Congress. Democrats hold a commanding 256-178 majority in the House of Representatives. Perhaps more importantly, Senate Democrats outnumber Republicans 57 to 40, with two Independent senators (Joe Lieberman of Connecticut and Bernie Sanders of Vermont) caucusing with the Democrats. With the Minnesota Senate race between incumbent Republican Norm Coleman and comedian Al Franken not yet resolved, Congress could conceivably vote on health care reform with the Democrats holding a filibuster-proof 60-seat majority in the Senate.

However, the challenge of enacting meaningful health care reform remains an uphill struggle. Americans have historically resisted government intervention in the delivery of health care, and they are often suspicious of the "socialized" health care systems of the UK and Canada, which are associated with waiting lists and rationing of care.

In addition, the cost of implementing the proposal to reform health care is staggering. Kenneth Thorpe, a health care analyst in the Clinton administration and now a professor at Emory University, estimates the cost of expanded coverage at $1.3 trillion to $1.8 trillion over 10 years.[4]

Health care reform proponents will argue that the cost can be offset by increasing the system's efficiency and avoiding waste and fraud. However, the potential cost of this effort, at a time of record deficits and massive public spending on "bailouts" and the economic stimulus, causes many Americans to remain skeptical of our ability to deliver and pay for the proposed reform measures.

Learning from Past Mistakes

It is clear that the Obama administration has learned from the mistakes that derailed previous efforts to reform health care. In contrast to the Clintons' approach, which incurred the wrath of the well-organized health insurance industry that, in turn, helped turn public opinion against the reform proposal through its "Harry and Louise" television commercials, Obama went to great lengths to include key stakeholders (and likely opponents) throughout the process, such as America's Health Insurance Plans (AHIP), Pharmaceutical Research and Manufacturers of America (PhRMA), American Hospital Association (AMA), and Service Employees International Union (SEIU).

Although some observers question how meaningful health care reform will actually be in the absence of a public plan option or mandates forcing Americans to purchase coverage, the Obama administration to date has been successful in avoiding direct confrontation over these controversial issues.

The White House and Capitol Hill

The Obama team made health care reform a central feature in the campaign and used the issue to successfully distinguish their candidate from presidential rival John McCain. Ultimately, however, the responsibility for developing and crafting legislation to reform our health care delivery system lies with Congress.

With friendly majorities in both the Senate and the House, prospects for the passage of this legislation look reasonably promising, but as with any issue so large and complex, there will be philosophical differences between the major power players.

Who Is in Charge?

There are several important health care policy leaders on Capitol Hill; however, in this case, the real action seems to be in the Senate, rather than the House. Within the Senate, the Health, Education, Labor and Pensions (HELP) Committee chaired by Senator Ted Kennedy (D-MA) and the Finance Committee chaired by Senator Max Baucus (D-MT) have so far been responsible for drafting legislation.

Both committees have issued detailed proposals outlining their vision for health care reform, and early copies of draft legislation have been circulating around the beltway.

Senate Finance Committee

The Senate Finance Committee released three reports outlining the committee's proposal for health care reform.

1. CNN Poll. Poll: Do Americans want government health-care reform? Available at http://politicalticker.blogs.cnn.com/2009/03/05/poll-do-americans-want-government-health-care-reform/. Accessed June 6, 2009.
2. Report: The costs of inaction. Available at http://www.healthreform.gov/reports/inaction/inactionreportprintmarch2009.pdf. Accessed June 6, 2009.
3. The Washington Post. U.S. healthcare lags despite highest spending. Available at http://voices.washingtonpost.com/fact-checker/2008/08/us_health_care_lags_despite_hi.html. Accessed June 6, 2009.
4. USA Today. Hurdles remain in Obama's push to re-vamp healthcare. Available at http://www.usatoday.com/news/health/2009-05-31-hurdles_N.htm. Accessed June 6, 2009.

The reports focused on the delivery system itself, coverage issues, and questions about financing – how we plan to pay for the health care reform effort.

Report One: Report on Delivery System Policy Options
The first of the three reports acknowledges that the way health care is paid for in our system does not always encourage the right care, at the right time, for each patient and notes that our payment systems more often reward providers for the quantity of care delivered than the quality of care and that they discourage providers from working together to offer patients the best possible care.

The report proposes linking payment to quality outcomes and reorienting payment incentives toward services and activities that improve patient care in an effective and efficient manner.

Payment for Transitional Care Activities
Notably, the report highlights the need for payment for transitional care activities and calls for integrated, transitional care management for chronically ill patients who experience hospitalization by reimbursing providers for targeted interventions that have proven successful in the Medicare Coordinated Care Demonstration program, the Medical Home, and other care management models.

Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration
The report also calls for the establishment of a Chronic Care Management Innovation Center (CMIC) for testing and disseminating payment innovations that foster patient-centered care coordination for high-cost, chronically ill Medicare beneficiaries. CMIC would be given permanent authority to broadly test care coordination models that show promise for improving the quality and cost-effectiveness of care delivered to chronically ill beneficiaries in fee-for-service Medicare.

Moving from Fee-for-Service to Payment for Accountable Care
Under existing law, there is no provision for directly addressing the ability of organizations or systems of integrated providers to share in the efficiency gains resulting from the joint responsibility and care of fee-for-service Medicare beneficiaries. The report calls for change in this policy to allow groups of providers who voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.

Health Care Infrastructure Investments – Tools to Support Delivery System Reform
The report focuses on providing and expanding authorized Medicare and Medicaid incentive payments and penalties to encourage physicians and hospitals to adopt and use electronic health records. However, it also calls for analyzing whether additional health information technology incentives within Medicare are warranted to help support the care coordination and quality improvement goals and activities related to various proposals included in this document, such as the establishment of value-based purchasing programs, chronic care management models, and proposals to bundle acute and post-acute payments.

Quality Measurement and Development
The report would require the establishment of a multi-stakeholder group to provide guidance to the Secretary in developing national priorities and goals and identifying gaps in performance measurement for national priority areas.

Measures would be applicable to all age groups, where appropriate, and available to the public, with a focus, at minimum, on the following areas:

- patient outcomes and functional status
- coordination of care across episodes of care and care transitions
- meaningful use of health information technology
- efficiency and equity of health services and health disparities
- patient experience and satisfaction
- other areas deemed appropriate in support of other delivery system reforms

Comparative Effectiveness Research
The report calls for the Finance Committee to consider options to establish a long-term or permanent framework to set national priorities for comparative clinical effectiveness research and to provide for the conduct of such research.

Finding Out What Works in Health Care – Comparative clinical effectiveness research compares clinical outcomes of alternative therapies or strategies used to prevent, treat, diagnose, and manage the same condition. The purpose of this type of research is to assist patients and clinicians in making informed health care decisions. Better evidence on what works will lead to better health care choices – and thus, to improved quality of care and improved efficiency.

Proposal on Development of a National Workforce Strategy
The Department of Health and Human Services (HHS), together with external stakeholders, would develop and set forth a national workforce strategy to put the nation on a path toward recruiting, training, and retaining a health workforce that meets our nation's current and future health care needs.

Report Two: Report on Coverage Reform Policy Options
The second report from the Senate Finance Committee focuses on expanding health care coverage and proposals to provide affordable coverage to all Americans. This report acknowledges the scale of the access issue in the United States – with 46 million uninsured and another 25 million underinsured – and notes that the cost of caring for the uninsured is largely borne by those with insurance; providers charge higher prices to patients with private coverage to make up for uncompensated care, and these costs are passed on to consumers in the form of increased premiums.

The first section of this report deals primarily with insurance regulation in the nongroup and small group markets. The report also calls for the creation of a Health Insurance Exchange, a concept in some ways similar to the Massachusetts Connector, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals at up to 300% of the federal poverty level who are not otherwise eligible for traditional Medicaid or other coverage and an unsubsidized selection of four benefit tiers from six insurers to individuals and small groups.

Making Coverage Affordable
The report would also require all health insurance plans in the nongroup and small group markets to provide a broad range of medical benefits including, but not limited to, preventive and primary care; emergency services; hospitalization; physician services; outpatient services; day surgery and related anesthesia; diagnostic imaging and screenings, including x-rays; maternity and newborn care; medical/surgical care; prescription drugs; radiation and chemotherapy; and mental health and substance abuse services, which must at least meet minimum standards set by federal and state laws. In addition, these plans cannot include lifetime limits on coverage or annual limits on any benefits and cannot charge cost-sharing (e.g., deductibles, copayments) for preventive care services.

Small Business Tax Credits
The report would provide a tax credit to certain small employers for the purchase of employer-provided health insurance.

Public Health Insurance Option
The report also calls for consideration of a public health insurance plan option and offers three broad design considerations:

- Medicare-like plan (operated by HHS)
- Third-party administrator (administered by multiple regional third-party administrators)
- State-run public option (could be either mandatory or optional for states, but the details of its administration would be left to the states)

Mandatory Coverage for Prescription Drugs
This option would make prescription drugs a mandatory benefit for the categorically and medically needy. Currently, prescription drug coverage is one of the few optional Medicaid services provided by all states.

Changes to Medicaid Payment for Prescription Drugs
Under this proposal, Medicaid law would be changed to increase the federal upper payment limits percentage from 250% to 300% of the weighted average (determined on the basis of utilization) of the most recent average manufacturer prices (AMPs) for pharmaceutically and therapeutically equivalent multiple-source drugs available nationally through commercial pharmacies. This proposal also would clarify which discounts and other price adjustments are included in the definition of AMPs.

Office of Coordination for Dually Eligible Beneficiaries
Medicare/Medicaid dual eligibles (referred to as duals) represent small percentages of Medicare and Medicaid beneficiaries, yet they are one of the most important beneficiary subgroups because, relative to their numbers, duals account for disproportionately large percentages of Medicare and Medicaid expenditures. To ensure that coordination for duals occurs, this proposal would establish a new office within CMS, the Office of Coordination for Dually Eligible Beneficiaries (OCDEB). The OCDEB would be responsible for identifying and leading agency efforts to align Medicare and Medicaid financing, administration, oversight rules, and policies for dual eligibles.

Shared Responsibility – Personal Responsibility Coverage Requirement
Under this proposal, every individual would have a personal responsibility requirement to obtain health insurance coverage. To ensure compliance, taxpayers would be required to report the months for which they have the required minimum coverage for themselves and family members on their federal income tax returns. The consequence for not being insured would be an excise tax equal to a percentage of the premium for the lowest cost option available through the Health Insurance Exchange for the area where the individual resides.

Employer Requirement
Currently, there is no federal requirement for employers to offer health insurance coverage to employees or their families. The report calls for the examination of various options that would make health insurance coverage mandatory for certain employers.

Promotion of Prevention and Wellness in Medicare
This option would authorize a personalized prevention plan for all enrolled beneficiaries once every 5 years unless deemed inappropriate. Beneficiaries would first receive a comprehensive health risk assessment including at least a complete medical and family history and age-, gender-, and risk-appropriate measurements (including height, weight, body mass index, and blood pressure if not already part of the patient's record). The assessment would also identify chronic diseases, modifiable risk factors, and emergency or urgent health needs.

Options to Prevent Chronic Disease and Encourage Healthy Lifestyles: "RightChoices" Grants
The option contemplates annual, capped grants to states for 3 or 5 years that would provide access to certain evidence-based primary preventive services such as tobacco use screening, influenza immunization, counseling on daily aspirin use, hypertension screening, or obesity screening for uninsured adults and children.

Prevention and Wellness Innovation Grants – Promotion of Team-Based Care
States would create locally integrated delivery systems including the establishment of multidisciplinary care teams. Multidisciplinary community health teams would be required to provide (1) comprehensive care management and patient and family support in conjunction with primary care providers; (2) care coordination and health promotion activities, including access to the range of services needed to maintain and improve health such as behavioral services and nutritional counseling, and coordination with local public health offices; (3) social and economic support to facilitate patient and family assistance with social support services and referral to and coordination with community-based programs; and (4) comprehensive transitional care from inpatient to institutional care settings, or care provided in community settings, as well as the assurance of appropriate follow-up.

Report Three: Report on Financing Reform Policy Options
Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options
The third and final section of the Finance Committee report focuses on the issue of rising costs in health care, noting that between 1999 and 2008, premiums for employer-sponsored health benefits increased 117% for families and individuals and 119% for employers. Annual health spending growth is expected to outpace average annual growth in the overall economy by 2.1 percentage points in each of the next 10 years. The report also notes that rising health care costs have a significant impact on federal and state health care programs.

Health Care Tax Subsidies
Tax subsidies and incentives for health care account for 17% of all tax expenditures.

Delivery system reform, reductions in health spending, and changes in the current tax treatment of health care alone may not pay for all of health care reform. Moreover, many proposals expected to reduce health spending in the long run may not produce sufficient savings in the short run to finance reform. The report calls for the consideration of other options to produce savings and generate revenues, including taxes that affect lifestyle choices and taxes that generally target loopholes.

Adjusting Reimbursement for High-Growth, Overvalued Physician Services
The committee will explore options that would make payments to Part B providers more rational through reforms that appropriately value services, such as the MedPAC recommendation to increase the utilization rate for calculating the payment for advanced diagnostic imaging services. Another option the committee could consider is the establishment of an expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services.

Increase the Medicaid Brand-name and Generic Drug Rebate Amounts
One option the committee could consider is increasing Medicaid's flat rebate from 15.1% to as much as 23.1%. Under this option, the Medicaid "best-price" provision would remain unchanged. Another option to consider is an increase in the basic Medicaid rebate for noninnovator, multisource drugs from 11% to 13% of the AMP.

Means Testing Part D Premiums
The committee could consider requiring beneficiaries whose incomes exceed certain thresholds to pay higher premiums for Part D drug coverage. Higher premiums could apply only to basic coverage. The income thresholds could be set at the same levels and adjusted in the same manner as under Part B.

Options to Modify the Exclusion for Employer-Provided Health Coverage
Several options could be considered that would limit the value of employer-provided health coverage that is excludible from gross income. The limit could be based on the value of the plan or the income of the insured, or the limit could be a combination of both. Alternatively, the limit could be tied to a percentage of the value of the employer-provided health coverage.

Another option would be to apply the limit only to taxpayers whose incomes exceed a threshold income level. A third option would be to limit the exclusion based on both the value of employer-provided health insurance and the income of the taxpayer.

Modify Health Savings Accounts
Health savings account (HSA) contributions could be limited to the lesser of the individual's deductible under the high-deductible health plan or the dollar amount of the maximum allowable aggregate HSA contributions. The additional tax on distributions from an HSA that is not used for qualified medical expenses would be increased to 20%. Distributions from an HSA would only be excludible from gross income as an amount used for qualified medical expenses if the employer or an independent third party substantiated the expenses. If a limit were placed on the current exclusion for employer-provided health coverage, HSA contributions could be counted against the limit.

Impose a Uniform Alcohol Excise Tax
This policy option contemplates imposing a uniform tax based on the alcohol content contained in the product. The excise tax under the proposal is imposed at a rate of $16 per proof gallon on all alcoholic beverages.

Enact a Sugar-Sweetened Beverage Excise Tax
The proposal would impose a federal excise tax per 12 ounces of sugar-sweetened beverage. Sugar-sweetened beverages under the proposal would include a variety of carbonated and uncarbonated beverages, such as nondiet soft drinks, fruit and vegetable drinks, functional drinks such as energy and sports drinks, iced teas and iced coffees, and flavored milk and dairy drinks.

The tax would apply to beverages sweetened with sugar, high-fructose corn syrup, or other, similar sweeteners. The tax would not apply to beverages sweetened with noncaloric sweeteners. Sugar-sweetened fountain-drink syrup would be taxed at a higher rate per ounce such that the rate per ounce of fountain drink would be roughly equivalent to the tax rate on ready-to-drink soft drinks.

Senate Committee on Health, Education, Labor & Pensions
A New Vision for American Health Care: Strengthening What Works and Fixing What Doesn't

- **Ensuring Reliable, High-Quality, and Affordable Health Insurance for All Americans**
- **Keeping in place what works today:** Those who are satisfied with their coverage will be able to keep it, even as we work to expand access, improve quality, and lower the rate of health spending growth for everyone.
- **Making health insurance work for all Americans:** Our health insurance system needs to work for everyone, not just the healthy and affluent; health insurance should be there for all Americans when we need it most.
- **Addressing the health coverage needs of those left out and those in danger of being left out:** We will reform our system so that everyone can get affordable and quality health insurance coverage, including almost 50 million uninsured Americans and those whose health insurance policies leave them medically and financially vulnerable.
- **Creating America's Health Benefit Exchange:** We want to create a new state-based resource to make

sure all Americans can easily obtain high-quality and affordable coverage.
- **Defining personal responsibility:** To make this new structure work for everyone, everyone needs to participate and obtain health insurance.

Improving Value by Creating a Higher-Quality, More Efficient Delivery System

A national strategy to improve health care quality is necessary to generate solutions to the biggest problems – medical errors, preventable hospital readmissions, and the failure to manage chronic diseases – which have a severe impact on people, their lives, their checkbooks, and national health care costs.

These are the key goals identified by the HELP Committee for quality and delivery system improvement we seek to achieve through comprehensive health care reform:
- preventing medical errors by using innovative tools and methods
- improving efficiencies in the delivery system by maximizing the use of health technology and simplifying administrative procedures
- preventing hospital readmissions by mandating discharge planning

Mandating hospital discharge plans that feature a discharge advocate working together with a pharmacist and others to coordinate hospital discharge, patient education, and medication reconciliation will reduce follow-up emergency visits and re-hospitalizations. Medication consultation, counseling, and education will assist patients in adhering to their medication plans. Establishing a system that allows hospitals to report readmission rates confidentially and providing them with a technical assistance program will help reduce their readmission rates. In addition,
- managing chronic conditions through better coordination and integration of care made possible by medical homes and community health teams
- strengthening the health workforce by increasing the number of practitioners and providing training and quality initiatives for existing practitioners
- reducing health disparities by ensuring they are considered in workforce programs and quality measures

Building a New Framework to Enhance Prevention and Wellness

These are the key goals in the Prevention and Public Health provisions of comprehensive health reform:
- reimbursing for essential preventive services
- removing barriers to preventive services
- promoting community wellness and strengthening our public health system
- changing medical school and residency curricula
- promoting the benefits of wellness and prevention
- encouraging workplace wellness programs
- creating a federal-level Prevention and Public Health Council

Financing Long-Term Services and Supports

Health care reform must ensure that vulnerable populations have access to coverage that meets their needs. For individuals with disabilities and seniors with chronic illnesses, long-term services and support are their primary unmet health care needs. These are critical to promoting health, preventing illness, and helping people function independently instead of in institutions. Ten million Americans need long-term services – personal care, assistive technology, and other supportive services – a number that will increase to 26 million by 2050. More than 200 million adult Americans lack protection for the costs of long-term services and supports. The nation lacks a coordinated, national, public-private system to deliver quality long-term services and supports. Nearly half of all funding for these services is now provided through Medicaid, which is a burden on states requiring individuals to become and remain poor to receive help.

These are key goals we hope to achieve through long-term services and supports:
- supporting America's workers with a new financing alternative for long-term services and supports
- promoting individual choice and independence through self-determination
- ensuring fiscally responsible and affordable premiums
- strengthening Medicaid for those who need it by reducing dependence on Medicaid for long-term services and supports
- retaining the role of private insurance in providing long-term services and supports

Rooting Out Fraud and Abuse

The National Healthcare Anti-Fraud Association estimates that at least 3% of all health care spending – or $72 billion in 2008 – is lost to health care fraud. Other estimates are as high as 10%. Fraud committed by providers, medical equipment suppliers, drug companies, and corrupt plan operators and brokers increases costs for everyone, puts the security and health of families at risk, and undermines public trust. The HELP Committee identified the following goals to advance the removal of fraud and abuse in the private sector and to link better private and public sector efforts:
- Establish a Healthcare Program Integrity Coordinating Council.
- Create senior-level positions at the Departments of Health and Human Services and Justice to coordinate health care antifraud activities.
- Address unauthorized and sham health insurance plans.

Establishing Shared Responsibility and Paying Appropriately and Fairly for Reform

Fixing America's health care system will provide real benefits for every individual and every part of our society – patients and consumers, businesses, hospitals, physicians and nurses, community health centers and other providers, health plans, business and labor, and government at all levels. Fixing this system will carry a cost – and the only way to make it work is to embrace the principle of shared responsibility. Everyone must take some responsibility to fix the system. This means that
- Individuals take personal responsibility to obtain quality health insurance affordable to them.
- Employers take responsibility for supporting the health coverage needs of their workers.
- Health insurers assume a different business model focused on meeting the health coverage needs of all Americans.
- Medical providers meet the challenge of reinventing medical care to improve care and to better use our health care dollars.
- Government at all levels is part of the solution.

Conclusion

The scope and scale of the discussion laid out in these reports is indicative of the challenges the Obama administration and Congress face as they attempt to pass and implement comprehensive health care reform.

Despite the hours of work and reams of paper already dedicated to this effort, the materials that have been officially released are still very broad, often discussing concepts and ideas rather than specifics.

Published details on the issue of pharmacists' clinical services are limited at best. Nevertheless, the materials clearly show a growing recognition of the need for an integrated, team-based approach to the delivery of care, an acknowledgment of the need to address and manage medication use, a renewed focus on prevention and wellness, a commitment to quality and outcomes in care, and a value-based approach to payment. The stalemate over the most controversial issues – such as a public plan option, mandates that require Americans to purchase coverage, and changes to the tax treatment of employer-based coverage – could yet derail this delicate process.

The Obama administration has been applauded for its efforts to reach out to key stakeholders and congressional leaders on both sides of the aisle and has so far avoided some of the mistakes made during the Clinton-era reform effort.

However, it remains to be seen whether the President can deliver on his promise that "healthcare reform must not add to our deficits over the next 10 years – it must be at least deficit neutral and put America on a path to reducing its deficit over time"[5] and, at the same time, deliver the health care reform he has promised.

WASHINGTON REPORT UPDATE

Health Care Reform Legislation Would Expand Access to Pharmacist Patient Care Services

Washington, D.C. – Legislation released June 9 by Health, Education, Labor and Pensions (HELP) Committee Chairman Edward Kennedy (D-MA) would expand access to pharmacist-delivered medication therapy management (MTM) services for patients suffering from chronic diseases.

The Affordable Health Choices Act – not yet introduced in the Senate – would provide grants to expand opportunities for pharmacists to deliver MTM services through local community-based, multidisciplinary health teams to patients who suffer from chronic diseases such as heart disease, cancer, and diabetes.

The announcement was welcomed by a coalition of 14 national pharmacy organizations established to raise awareness about the human and financial costs of inappropriate medication use.

The U.S. health care system currently incurs more than $177 billion annually in mostly avoidable health costs to treat adverse drug events from the inappropriate use of medications. In addition, the treatment of chronic disease costs our health system $1.3 trillion annually – about 75 cents of every health care dollar.

The MTM services provided by pharmacists, working with physicians and other health care providers, help improve therapeutic outcomes, reduce medication errors and adverse drug events, enhance coordination of care, improve patients' overall quality of life, and reduce overall health care costs.

The pharmacy profession, encompassing all practice settings, applauds the Senate HELP Committee proposal for identifying the problems associated with inappropriate medication use and for recognizing the important role of pharmacists as providers of clinical care services, which can improve the quality of patient care by focusing on appropriate medication use and contribute to reducing overall costs in the treatment of chronic diseases.

The coalition particularly recognizes the efforts of Senators Kennedy, Dodd (D-CT), Enzi (R-WY), Gregg (R-NH), and Mikulski (D-MD), who worked hard on behalf of patients to secure these important provisions.

The 14 coalition members are:

American Association of Colleges of Pharmacy (AACP)
American College of Clinical Pharmacy (ACCP)
Academy of Managed Care Pharmacy (AMCP)
American Pharmacist Association (APhA)
American Society of Consultant Pharmacists (ASCP)
American Society of Health-System Pharmacists (ASHP)
College of Psychiatric and Neurologic Pharmacists (CPNP)
Food Marketing Institute (FMI)
National Alliance of State Pharmacy Associations (NASPA)
National Association of Chain Drug Stores (NACDS)
National Community Pharmacists Association (NCPA)
Rite Aid Corporation
Safety Net Hospitals for Pharmaceutical Access (SNHPA)
Walgreens

Student Meeting Travel Fund Gains Momentum

Make a Tax-Deductible Contribution to Support Increased Student Involvement in ACCP

During the past year, the College has continued to promote student involvement in a variety of ACCP activities and services, including attendance at its national meetings. These opportunities provide students with a broad exposure to clinical pharmacy and the chance to participate in ACCP at the national level. In light of the recent economic downturn, encouraging student meeting attendance has been hampered by a major factor: limited student financial resources. ACCP members, the PRNs, and local Chapters all have continued to support the Student Meeting Travel Fund in an effort to alleviate some of the students' economic burden associated with attending the College's national meetings.

The Student Meeting Travel Fund provides financial assistance to students who wish to attend an ACCP meeting. Since the debut of the Best Student Poster competition, a growing number of students have expressed interest in submitting posters for presentation and attending ACCP

5. Washington Post Editorial: President Obama's first foray into the details of health-care reform. Available at http://www.washingtonpost.com/wp-dyn/content/article/2009/06/07/AR2009060702019.html AR2009060702019.html. Accessed June 8, 2009.

meetings. The number of student registrants, as well as the number of student abstract submissions, continues to increase steadily. In addition, there is a growing range of opportunities for student pharmacists within ACCP, including the opportunity to serve on the National StuNet Advisory Committee. However, students are still confronted with covering the costs of travel, hotel, and meeting registration. ACCP's Student Meeting Travel Awards help defer a portion of the costs associated with meeting attendance. Member response has been very positive to this new initiative. Since its debut in 2006, nearly 140 students have received student travel awards to support attendance at ACCP national meetings. ACCP members are encouraged to help support these future clinical pharmacists. Most individual members have made contributions of $25 to $100, but any amount will be gratefully accepted! There are three ways members can make a tax-deductible contribution to the fund:

- Contact ACCP Customer Service at (913) 492-3311 to use a credit or debit card to make a contribution.
- Mail a check, payable to "ACCP Student Meeting Travel Fund" to: ACCP, 13000 W. 87th St. Parkway, Lenexa, KS 66215-4530.
- Make a contribution while registering for the 2009 Annual Meeting by indicating the amount you wish to contribute on the meeting registration form.

PRNs or chapters interested in making a donation may contact Jon Poynter, Membership Project Manager, at (913) 492-3311, or e-mail at jpoynter@accp.com. Remember, your financial support will benefit student pharmacists who might not otherwise be able to attend an ACCP meeting. All funds collected are allocated directly to student travel awards. Administrative costs of managing the awards process are covered by the College's student membership budget.

Pharmacotherapy Pearls

Facts and Comparisons

Wendy R. Cramer, B.S., FASCP
Richard T. Scheife, Pharm.D., FCCP

With 2008 behind us, we would like to share with you some of *Pharmacotherapy's* performance measures. As you will see, the performance of the journal has continued to trend in a very positive direction.

New Manuscript Submissions to *Pharmacotherapy*[a]

Year	No. of Submissions
1995	171
1996	205
1997	216
1998	228
1999	233
2000	309
2001	291
2002	308
2003	365
2004	395
2005	353
2006	473
2007	476
2008	473

[a]Excludes supplements.

Numbers of Articles and Pages Published[a]

Year	No. of Articles	No. of Pages
1995	106	832
1996	153	1224
1997	180	1351
1998	165	1380
1999	194	1462
2000	186	1515
2001	189	1578
2002	202	1635
2003	198	1666
2004	206	1807
2005	202	1820
2006	217	1811[b]
2007	197	1762
2008	177	1544

[a]Excludes supplements and advertising pages.
[b]As of 2006, ACCP abstracts were no longer printed in the journal (available online only); number of pages published represents articles only.

Manuscript Turnaround Time

Turnaround times from time of manuscript receipt to accept/reject judgment, time for author to complete all revisions, and time from acceptance of final revision to publication are as follows:

Mean Time (mo)

Year	Manuscript Receipt to Judgement	Revision Time	Revision Receipt to Publication	Total Turn-around Time
1995	2.3	1.8	6.5	10.6
1996	2.3	1.9	7.9	12.1
1997	2.1	1.8	5.2	9.1
1998	2.1	1.9	4.8	8.8
1999	1.9	1.8	4.5	8.2
2000	1.9	1.9	3.8	7.6
2001	2.0	2.0	3.2	7.2
2002	2.0	2.1	3.0	7.1
2003	2.1	1.9	3.3	7.3
2004	1.8	1.2	5.1	8.1
2005	1.6	1.7	5.3	8.6
2006	1.5	1.6	5.3	8.4
2007	1.9	1.1	5.2	8.2
2008	1.8	1.3	5.3	8.4

Faculty and Investigator Participants Return to Utah for the Focused Investigator Training (FIT) Program

A cadre of 12 highly experienced faculty mentors and 16 participants are set to arrive at the University of Utah for the second annual FIT Program next month. The 16 experienced investigators who were selected to attend the Program possess the knowledge and skills required to submit

a competitive extramural funding grant such as the NIH. The 16 participants selected to attend the FIT Program are as follows: Kim Adcock, Larry Dent, Cynthia Jackevicius, Effie Kuti, Jeannie Lee, Tien Ng, Asad ("Sid") Patanwala, Hanna Phan, Terri Warholak, Eric Ip, Sally Huston, Jean-Venable "Kelly" R. Goode, Amy Franks, Carrie McAdam Marx, Joshua Caballero, and Nicholas Norgard. Throughout the week, these 16 investigators will maximize pilot data while working with highly funded, experienced mentors from around the country in a collegial setting.

The core activity of the FIT, called the *Grant Proposal Group Sessions,* teams the investigators with two faculty mentors and two other peer investigators throughout the week. In addition to lectures, participants will engage in panel discussions and small group breakout sessions for basic, clinical, and health outcomes research topics. Moreover, participants will have ample opportunity to consult with all the NIH-funded FIT Program faculty mentors, which include two biostatisticians, during one-on-one office hours.

"The success of the program hinges upon the right combination of NIH-funded faculty and participants hungry to take their careers to the next level," said Susan Fagan, Chair of the Research Institute Board of Trustees. The 2009 FIT Mentor Team is as follows: Drs. Barry Carter, John Cleary, Reginald Frye, Susan Fagan, Lynda Welage, Gene Morse, and Mark Munger; Mary Gerkovich, Ph.D.; Greg Stoddard, Ph.D.; Julie Wright; and Gary Yee.

The FIT Program is partially supported by an educational donation provided by Amgen and in-kind support from the host institution, University of Utah, College of Pharmacy. The American College of Clinical Pharmacy is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. The 2009 Focused Investigator Training (FIT) Program will provide up to 32.5 contact hours of continuing education credit.

PRNs Support Members to Attend the Focused Investigator Training (FIT) Program

Four PRNs offered tuition stipends to its members who are selected to attend the 2009 FIT Program. Kutie Effie is supported by the Adult Medicine (AMEN) PRN, Asad ("Sid") Patanwala by the Critical Care (CRIT) PRN, and Hanna Phan by the Infectious Disease (INFD) PRN. There were no FIT applicants from the Hematology/Oncology (HMON) PRN this year to accept their stipend. The Research Institute thanks these four PRNs for supporting their members in scholarly development and welcomes others PRNs to offer similar support for their members for the class of 2010 and beyond.

Awards, Promotions, Grants, etc.

Daniel Buffington, Pharm.D., MBA, was recently presented with the Distinguished Alumnus Award by the Mercer University College of Pharmacy and Health Sciences…. **Diane Cappelletty**, Pharm.D., has been elected President of the Society of Infectious Diseases Pharmacists…. **Marie Chisholm-Burns**, Pharm.D., FCCP, is the principal investigator on a project titled, "Medication Access Program," that was recently awarded $998,072 from the Mason Trust….**James Cloyd**, Pharm.D., FCCP, has been elected to a 3-year term on the American Epilepsy Society Board of Directors….**Erika Kleppinger**, Pharm.D., BCPS, CDE, has been promoted to Clinical Associate Professor at Auburn University Harrison School of Pharmacy….**Greg Leader**, Pharm.D., was recently named Interim Dean at the University of Louisiana at Monroe College of Pharmacy…. **Vince Mauro**, Pharm.D., FCCP, has been appointed Vice Chair of Clinical Affairs in the Department of Pharmacy Practice at the University of Toledo College of Pharmacy…. **Mary Lynn McPherson**, Pharm.D., BCPS, and **John Murphy**, Pharm.D., FCCP, have each been elected a Distinguished Practitioner in the National Academies of Practice of Pharmacy. Dr. Murphy also recently delivered the 2009 Leonard Lecture at the University of Texas College of Pharmacy….**Mark Schneiderhan**, Pharm.D., BCPP, has been appointed Associate Professor of Pharmacy Practice and Pharmaceutical Sciences at the University of Minnesota College of Pharmacy….**Peter Vlasses**, Pharm.D., FCCP, BCPS, was recently awarded an honorary doctor of science degree by the Mercer University College of Pharmacy and Health Sciences….**Kurt Wargo**, Pharm.D., BCPS, has been promoted to Clinical Associate Professor at Auburn University Harrison School of Pharmacy.

New Members

Lise Aagaard
Felicia Abaab
Shirin Abadi
Houry Abajian
Ahmed Abdelaziz
Sherif Abou El Naga
Daria Accaputo
Emanuela Adele De Francesco
Ayne Adenew
Donna Adkins
Douglas Adriance-Mejia
Marja Airaksinen
Mohammed Al-Anazi
Ali Albahrani
Laurentia Alecsandru
Fatima Alhaddad
Hamdan Almas
Eman Al Obary
Fahad Al Saikhan
Mohammed Alsultan
Dalal Al-Taweel
Magda Alvarez
Emma Andrews
Teresa Anekwe
Daniele Antonelli
Sotiris Antoniou
Enrica Arduini
Sara Arenas-Lopez
Craig Arneson
Daniel Ashwood
Randall Atkinson
Abdelmoneim Awad
Roxanne Badr
Fadel Balawi
Jeanenne Baldwin
Angelo Barcella
Catrin Barker
Gina Barnes
Vanni Bascape
Christy Bassel
Kate Bean
Eric Beaudoin
Scott Bebensee
Pierrick Bedouch
Elin Bergene
Daria Bettoni
Amanda Bevan
Debi Bhattacharya
Edward Billings
Joseph Biskupiak
John Blee
Aurora Boboc
Angela Bottalico
Olivier Bourdon
Caitlin Bowers
Chris Boyer
Rachel Boyer
Kara Boyko Frandson
Jeanne Brady
Luigi Brambilla
Christopher Brennick
Mélanie Brignone
Christina Brizendine
Desirea Broome
Dana Brown
Taofik Brown
Michele Bryant
Susan Brzozowski
Cynthia Budzinski
Betty Burns
Holly Busic
Abby Bussey
Graciela Calle

Andrea Cammilli
Matthew Campbell
Carrie Capak
Kevin Castano
Jessica Cather
Karen Caylor
Michele Cecchi
Andrea Chamberlain
Carol Chamberlain
Julie Chan
Claire Chapuis
Nikodimos Chatzigeorgiou
Eric Chernin
Amy Chung
Luciana Ciboldi
Didina Cicirlan
Roberto Codino
Philippe Colucci
Sorin Constantin
David Copelan
Danielle Coppola
Cosimo Costa
Joshua Courter
Marcus Cox
Martha Cross
Scott Dallas
Mikael Daouphars
Brenda Darling
Priyanka Dave
Sarah Davis
Kristina Dawson
Charles Day
Pieter De Cock
Maria Sandra Deidda
Dixie Dela Vega
Christopher Dennis
Mauro De Rosa
Rajshree Desai
James Desborough
Franciska Desplenter
Henrietta Dieleman
Yvonne Dijstelbloem
Aleksandra Dimitrovska
Myle Do
Thanh Doan
Tara Doleman
Gilles Dollo
Tracy Doney
Beatrice Drambarean
Tobias Dreischulte
Benjamin Dropkin
Harold Duncan
James Dunlap
Michaelia Dunn
Cynthia Dusik
Jean-Claude Dutat
Natasha Edmondson
Manal El-Hamamsy
Lina Eliasson
Jason Ellison
Ostojski Elodie
Ehijie Enato
Tonya English
Maria Enrica Proli
Christine Ernes
Stephen Esker
Mark Essak
Hansel Esteller
Morgane Ethgen-Bonnet
Daniele Evenadin
Kristin Fabbio
Michelangela Fabbrocini
Stanislav Fabianich
Irini Fadl
Rashida Fambro
Fabio Fanfarillo
Oyejoke Fasoranti
Andrea Fender
Fernando Fernandez-Llimos
Lori Fiallo
Janet Finch
Carla Findlater
Pietro Finocchiaro
Simona Firulescu
Dan Fisher
Andrea Flavio Gioia
Janet Flynn
Ada Foglia
Marta Maria Fonteles
Caroline Fonzo-Christe
Karla Foster
Karen Fraraccio
Jeremy Fredell
Beth Fullmer
Misilene Fulse
Galileo Galeon
Alex Ganetsky
Cynthia Garris
Lindsay Garris
Lauren Gaulke
Nicole Gebran
Amanda Geist
Melissa Gervase
Larry Gever
Cara Gilchrist
Andrea Gill
Syed Gillani
Aulagner Gilles
Vicki Glidewell
Franca Goffredo
Luis Gonzalez-Parra
Autumn Gordon
Andries Gous
Peer Graaf
Brent Gravelle
Kristen Grondin
Christopher Guertin
Christian Guillaume
Harleen Guraya
Payal Gurnani
Yvan Hagay
Laura Hall
Don Hamilton
Lidwien Hanff
Ebba Hansen
Andrew Hart
Heather Haug
Renee Heimbigner
Beaussier Helene
Mary Hencher
Yolanda Hernandez Gago
Alan Herrera
Eduardo Hidalgo
Jamie Hogerheide
Michal Hojny
Loretta Holmes
Jessica Hoon
Petr Horak
Wobbe Hospes
Julie Huang
Michael Huke
Amanda Hulbert
Daniel Hwang
Dolores Iaboni
Ivana Ilickovic
Paola Incitti
Eric Ip
Michael Izquierdo
Kayode Jacobs
Travis Jacobs
Petra Jancar
Harjot Jassal
Heidi Jendro
Melissa Johnson
Penelope Johnson
George Jones
Irvin Jones
Maria Jones-Harrison
Jeanette Jonsson
Anna Jung
Flavius Jurcau
Michael Kallenberger
Elif Kaya
Christina Kelly
Jennifer Kelly
Sharon Kennedy-Norris
Cindy Kenyon
Brian Keys
Azra Khan
Aaliyah Khatib
Joong Kim
Yuliya Klopouh
Hannelore Kreckel
Alison Kunk
Rhonda Kvetko
Jamie Ky
Joyce Lai
Wan Ki (Wendy) Lam
Guillaume Landry
Victor LaPorte
Joseph LaRochelle
Marianne Laseur
Vincent Launay-Vacher
Pierre Laurent
Petra Laveno
Graham Lawson
Anh Le
Kimberly Le
Betty Lee
Elin Lehnbom
Nicholas Leon
Patrick Leong
Michelle Lese
Radmila Levinson
Zhiping Li
Stephanie Liang
Maria Lourdes Libre
Stephan Linden
Cartia Linden-Lahti
Hui-Ping Liu
Xiaoqing (Frank) Liu
Yi Yu Liu
Maureen Lloy
Laura Lo Castro
William Loeffler
Gabriel Lopez
Carmen López-Cabezas
Lucia Losco
Mirjana Lulic-Botica
Sarah Lyons
Debra Macdonald
Molly MacDonnell
Lisa Maher
Sekhar Mamidi
Dana Manning
Saux Marie Claude
Harrie Martens
Angela Martinez
Janne Marvola
Matthew Maughan
Isidoro Mazzoni
Rowena McArtney
Tamera McFarren
Ronald McGrier
Luis Maria Mendarte
Nathalie Merle
Kim Messier
Julie Methot
Carla Meyer-Massetti
Gerardo Miceli Sopo
Celine Michel
Marcia Minnich Barnes
Alissa Mittereder
Felicia Moody
Jetavia Moody
Wayne Moore
Matthew Moran
Chad Morton
Carol Motycka
Kylie Mueller
Hilda Ndikum
Claudio Negri
Kaspar Ng
Ying Ru Ng
Huy Ngo
Michael Nguyen
Viet-Huong Nguyen
Penelope North-Lewis
Peter Noyce
Per Nydert
Atieno Ojoo
Zachary Oleszczuk
Florence Ollivier
Melissa O'Neill
P. David Pacheco
Darren Palmer
Angelo Palozzo
Elena Pana
Alex Pang
Marcello Pani
Maria Pardo
Caroline Pare
Sunghee Park
Emilia Paska

Badal Patel
Bhamini Patel
Revati Patel
Saguna Patel
Mauricio Patino
Stephen Perona
Christine Perras
Lisa Perry
Michael Perry
Rebecca Perry
Scott Perry
Daisy Peterson
Timothy Peterson
Laurent Petit
Shashikant Phadtare
Khanh Phan
Lara Picard
Linda Pien
Andrea Pierini
Christina Piro
Theresa Pistorino
Jennifer Pluim
Robert Poole
Floarea Popa
Thomas Popelka
Ileana Popescu
Louis Portas
Julie Pouzoulet
Faith Pranno
Valerie Prost
Katheryn Pruitt
Madhavi Puppala
Kellie Rademacher
Sundaram Ramasamy
Franco Rapisarda
Manal Rassam
Shanna Reding
Timothy Reilly
Sophia Reinhard
Sara Revolinski
Jeong Yeon Rhie
Monica Ricci
Thomas Richards
Korin Richardson
Nancy Ritchardson
Elise Rochais
Michael Roe
James Roemer
Rebekah Roemer
Joshua Rolin
Eric Rose
Vesna Rosovic-Bazijanac
Charlotte Steenberg Roth
Helena Rotterova
Karl Ruch
Mojdeh Saba
Sohel Sachak
Anne Sadofsky
Priyabrata Sahoo
Rachel Samples
Karen Sando
Shauna Santare
Rachel Sarabia-Leech
Anna Sarfati
Sally Sato
Natalie Schellack
Paolo Schincariol
Deidra Schmidt
Anna Schor
Angela Schuman
George Schwobel
Lucy Schwobel
Andrea Scobie
Heather Searcy
Robert Segal
Géraldine Senon
Ji Yeon Seo
Michael Sepulveda
Liza Seth
Vishal Shah
Kirsten Shell
Simon Shepherd
Maria Silva Abreu
Steven Simoens
Erin Simone
Maria Simunkayova
Preeti Singh
Angela Smith
Denise Smith
Jason Smith
Tavis Smith
Mitch Sobel
Gary Sorensen
Heidi Sorensen
Abinette Soto
Jennifer Soun
Stephen Speilberg
Dennis Sperle
Susan Spivey
Silvana Stecca
Nancy Stecher
Jihan Suliman
Sharon Sutton
Inese Sviestina
Leanne Svoboda
Gaudin Sylvie
Kriszta Szrnka
Michelle Tallgrass
Leslie Teague
Erica Tenholder
Erin Thatcher
Michelle Thomas
Alicia Thorne
Phillip Thornton
Kimberly Tignor
Betty Torres
Sylvia Torres
Kristy Tran
Brittany Traylor
Andrew Trella
Cynthia Trespalacios
Enrico Troiano
Th. (Dick) F.J. Tromp
Catherine Tuleu
Rachel Tunrarebi
Phuong Turner
Vincenzo Ummarino
Lonneke Van Aart
Annemarie Van Der Aart
Berry Van Schaik
Jacqueline Vasquez
Kristin Vaughan
Kari Vavra
Libor Vejnar
Adriano Vercellone
Michiel Verhulst
Charlotte Verrue
Christina Victor
Diem Vo
Arnold Vulto
Christopher Vynanek
Julie Waldfogel
Chiny Wang
Bruce Warden
Anthony Ware
Ahmad Wehbi
Danelle Wells
Aaron Whitten
Michelle Wilde
Sandy Willan
Joseph Williams
Nicole Williams
Steve Williams
Mya Wilson
Corey Wirth
Edric Wong
Ian Wong
Linda Wong
Tina Wong
Anita Woo
Kendra Worthy
David Wright
Dode Xavier
Jarrett Yara
Brian Yarberry
Sarah Yarborough
Candice Yong
Ahn Young
Wisener Young
Kennith Yu
Julia Zingel

The Following Members Recently Advanced from Associate to Full Member:

Keith Adcock
Lulu Al-Balbeesi
Nada Alqadheeb
Forrest Batz
Misty Boachie
Martin Breen
Kimberly Burkhalter
Tim Chen
Nella Desai
Heike Doerr
Kevin Doherty
Bryan Dotson
Benjamin Duhart
Joslyn Emerson
Kelly Estremera
Renee Freitag
Jennifer Gatsos Walter
Radhan Gopalani
Hye-Sun Gwak
Gina Harper
Jon Hiles
Ammie Hodges
Sally Huston
Rob Hutchison
Diane Johnson
Shawn King
Lyle Kolnik
Adam Landers
Sharon Liaw
Kristjon Lindgren
Anh-Vuong Ly
Corrie Martin
Sonia Mathews
Pamela Moore
Kesha Morgan
Audrey Ng
Sean Nguyen
Anish Patel
Bryan Phan
Dax Quelland
Cathlene Richmond
Mauricio Rodriguez
Xin Ruppel
Veena Rushi
Ken Saunders
Bresha Shaw-Franklin
Valerie Sheehan
Tracie Shimizu
Jennifer Siedlecki
Karen Snow
Bernard Sorofman
Brandon Sucher
Phiyen Tra
Rachelle Velasquez
Alison Walton
Sarah Williamson
Valerie Woerndle
Aylin Yucel
Emre Yucel

New Member Recruiters

Many thanks to the following individuals for recruiting colleagues to join them as ACCP members:

Elias Chahine
Jean Dib
David Ferris
Paige Fuller
Nicholas Hummel
Julie Kissack
Michelle Lau
Joel Marrs
John Murphy
Michelle Richardson
Renee Smith
William Terneus
Eric Tichy