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Wells Named 2012 Parker Medalist

Barbara G. Wells, Pharm.D., FCCP, BCPP, has been chosen by the Parker Medal Selection Committee as the 2012 recipient of the College's Paul F. Parker Medal for Distinguished Service to the Profession of Pharmacy. Dr. Wells is professor and dean emeritus at the University of Mississippi School of Pharmacy, and executive director emeritus of the school's Research Institute of Pharmaceutical Sciences, in Oxford, Mississippi.

Paul Parker was one of clinical pharmacy's most influential proponents. Before his death in 1998, Dr. Parker spent 24 years as director of pharmacy at the Chandler Medical Center/University of Kentucky in Lexington. His innovations include developing decentralized pharmacy services, placing pharmacists in the hospital's clinical areas, and developing the nation's first pharmacist-staffed drug information center. Dr. Parker's vision for pharmacy practice was passed along to the more than 150 residents and fellows who trained in the Kentucky program during his tenure. These disciples include many of today's leaders in clinical pharmacy who continue to pass on his wisdom and vision to their trainees. The Paul F. Parker Medal recognizes an individual who has made outstanding and sustained contributions to the profession that improve patient or service outcomes, create innovative practices, affect populations of patients, further the professional role of pharmacists, or expand the recognition of pharmacists as health professionals.

In making its selection, the Parker Medal Selection Committee commented on Dr. Wells' many contributions to clinical pharmacy and the pharmacy profession, noting that she has served as "an inspiring pharmacy practitioner, educator, mentor, administrator, advocate, and leader." The committee went on to say, "Her sustained and capable servant leadership within a host of major pharmacy organizations … is testimony to her amazing skill and commitment to shaping the pharmacy profession." Dr. Wells' career has encompassed numerous leadership roles in pharmacy practice, education, and pharmacy associations. She served as chair of the Department of Pharmacy Practice at Samford University and dean at Idaho State University College of Pharmacy and the University of Mississippi School of Pharmacy. Dr. Wells was elected as the 2002–2003 president of the American Association of Colleges of Pharmacy (AACP) and 2004–2005 president of ACCP.

She has received several awards, including the 2010 American Pharmacists Association's (APhA) Gloria Niemeyer Francke Leadership Mentor Award, the APhA Clinical Pharmacotherapeutic Award, the AACP Robert C. Chalmers Distinguished Educator Award, and the ACCP Education Award. Dr. Wells has been elected as a Fellow of ACCP, ASHP, and ASCP and, in 2004, was inducted as a member of the Academy of Pharmacy Practice of the National Academies of Practice.

Dr. Wells' nominator, Stephanie Phelps, wrote in her letter of nomination,

> I believe Barbara's greatest legacy will be her commitment to developing leaders within our profession. Her heart for the personal and professional development of those she trained and worked with is always evident. She has been an important role model for hundreds, and perhaps thousands or pharmacists and student pharmacists over her career. She has mentored numerous men and women who belong to different generations and who have been at various points in their professional careers.

Joseph DiPiro, Pharm.D., executive dean of the South Carolina College of Pharmacy, wrote in his letter of support,

Two words that have characterized Dr. Wells for many years are "mentorship" and "leadership." Dr. Wells is a mentor to many people in pharmacy education, senior as well as junior, and has always been very vocal about the need to promote mentorship in our academy. She is one of the best examples I have seen of a caring mentor. Dr. Wells exemplifies the important qualities of leadership and has often spoken on this topic. While serving as President of AACP and ACCP she made a strong part of her agenda to develop leaders within the organizations.

University of Mississippi School of Pharmacy Associate Dean and Department Chair Leigh Ann Ross, who worked closely with Dr. Wells at the University of Mississippi, added,

I watched Dean Wells as she invested time in each and every member of our faculty, especially those in leadership positions. She mentors, advises, and encourages all to develop the skills they need to be successful. Her door was always open and she was always ready to provide good counsel. Of particular note, she has served as a positive role model for women in pharmacy academics and in clinical practice. She was one of the first women to serve as a department chair in a school of pharmacy in the U.S., and was the third woman appointed dean in a College of Pharmacy in the continental U.S. I am confident that the emphasis she places on mentorship and her own personal experience in developing future leaders within our profession is part of her legacy that will impact pharmacy for years to come.

The 2012 Paul F. Parker Medal will be presented during the Opening General Session at the 2012 Annual Meeting in Hollywood, Florida, on Sunday morning, October 21. Dr. Wells will attend to accept the medal and deliver a brief acceptance address. The Parker Medal Selection Committee is composed of representatives from member organizations of the Joint Commission of Pharmacy Practitioners, together with past presidents of ACCP. Members of the 2012 committee are John Bosso (chair), Jeffrey Baldwin, Bradley Boucher, Harold Godwin, Thomas Hardin, Dennis Helling, Lynnae Mahaney, Robert Smith, Shelly Spiro, and Barbara Zarowitz.

Should Organized Clinical Pharmacy Promote a Consistent Process of Patient Care Provided by Clinical Pharmacists That Can Apply to Any Clinical Practice Setting?

Part IIIB: Application of Major Practice Models to Sample Cases

2012 ACCP Public and Professional Relations Committee[a]

Editor's note: This is the fourth installment of a multipart commentary prepared expressly for the May through September 2012 issues of the ACCP Report.

In this fourth installment of the series, we provide two illustrative cases as examples of how a clinical pharmacist would approach and document a patient in two different settings using the five models discussed in part II (http://www.accp.com/report/index.aspx?iss=0612&art=1) and part IIIA (http://www.accp.com/report/?iss=0712&art=2). One case involves a primary care setting, and the other focuses on an acute care setting. The clinician's approach and documentation are included in each case for the five models: Pharmaceutical Care; Medication Therapy Management (MTM); Patient-Centered Primary Care Collaborative (PCPCC), MTM in the Patient-Centered Medical Home (PCMH); the Society of Hospital Pharmacists of Australia (SHPA); and individualized Medication Assessment and Planning (iMAP). These examples are offered to help the reader visualize the applications of each model and thus compare and contrast the various approaches to specific patients.

Primary Care Patient Case Example

Chief Complaint (CC): K.G. presents to your clinic for a follow-up. You work in an interprofessional clinic with physicians. He has no complaints today.

History of the Present Illness (HPI): K.G. is a 55-year-old white man who was given a diagnosis of hypertension (HTN) 6 months ago by his family physician. At that time, his physician recommended dietary modifications and an exercise regimen. K.G. generally adhered to the lifestyle changes, losing 20 lb in 3 months, yet his BP continued to be elevated. At that time, his physician initiated lisinopril 10 mg once daily. At his physician visit today, you are consulted about his persistently elevated BP readings and are asked to see the patient. K.G. also expresses interest in quitting smoking.

Medical History:

Disease:

HTN x 6 months

Osteoarthritis (OA) of knee x 2 years

Surgical:

None

Medication History:

Allergies/Intolerances: No known drug allergies (NKDA)

Immunization History: Up-to-date

Current Medications:

Start	Medication	Strength (mg)	Sig	Indication	Comments
2 years ago	Ibuprofen (Motrin)	400	1 tablet po q6h prn pain	OA	Taking 2 tablets one to three times/day for 2 years
3 months ago	Lisinopril	10	1 tablet po once daily	HTN	

Family History:

Father: Living; acute myocardial infarction (MI) at age 55

Mother: Died of breast cancer at age 55

Children: No health problems

Social History:

Tobacco: Has smoked 1 pack/day x 30 years

Alcohol: Denies alcohol use

Diet: Low fat/low sodium/high fiber

Exercise: 30 minutes/day, three times/week

Review of Systems (ROS):

Cardiovascular (CV): Denies chest pain (CP)

Pulmonary (Pulm): Denies shortness of breath (SOB) or cough

Gastrointestinal (GI): Denies nausea, vomiting, diarrhea, and constipation (N/V/D/C); denies heartburn or dyspepsia

Extremities (Ext): Denies edema; reports 3/10 pain on most days and 5/10 on days after exercising

Physical Examination:

General: No abnormality detected (NAD)

Head, eyes, ears, nose, throat (HEENT): Pupils equal, round, reactive to light, and accommodation (PERRLA); extraocular movements intact (EOMI); funduscopic examination reveals no hemorrhages, exudates, or papilledema; no bruits

CV: Regular rate and rhythm (RRR), no murmurs, rubs, [or] gallops (m/r/g)

Pulm: Clear to auscultation bilaterally (CTAB)

Ext: No edema

Vital Signs:

Today:

BP 158/92 mm Hg, 152/94 mm Hg

Heart rate (HR) 60 beats/minute; respiratory rate (RR) 14 breaths/minute; Temp 98.4°F; Ht 6′0″; Wt 210 lb

3 months ago:

BP 166/98 mm Hg (average of two readings)

HR 62 beats/minute; RR 16 breaths/minute; Temp 98°F; Ht 6′0″; Wt 215 lb

BP readings from past 3 months (from local pharmacy):

152/90
158/92
166/96
160/90
156/92
150/88
152/90
154/92

Laboratory Data:

Today at 8:30 a.m. (fasting):

		Normal Range
Na	138 mEq/L	136–145
K	4.0 mEq/L	3.5–5.0
Cl	104 mEq/L	96–106
CO_2	27 mmol/L	24–30
BUN	14 mg/dL	8–20
SCr	1.02 mg/dL	0.7–1.5
Glu	86 mg/dL	70–110
Total cholesterol	250 mg/dL	NA
HDL	38 mg/dL	NA
LDL	184 mg/dL	NA
TG	140 mg/dL	NA

Studies:

Electrocardiogram (ECG) (5/6/2011): Normal sinus rhythm (NSR); no other abnormalities noted

Pharmaceutical Care Application

Collect patient-specific information
(as previously summarized).

Includes Pharmacotherapy Workup
In this interprofessional setting, the review of systems by the pharmacist is not necessary, as it was already done by the physician. The Pharmacotherapy Workup also includes asking the patient about his or her existing medical conditions to determine what conditions exist. In a setting such as a community pharmacy, this would be important, but in this setting, it is not necessary as all the medical conditions are already in the medical record.

Analyze clinical data (reported below).

Identify drug-related problems.
- Effectiveness: Dosage too low – BP elevated despite treatment with lisinopril 10 mg once daily
- Safety: Adverse drug reaction – Ibuprofen may be increasing BP.
- Indication: Needs additional drug therapy for new diagnosis of dyslipidemia
- Indication: Needs additional drug therapy for smoking cessation
- Indication: Needs additional drug therapy for MI prevention (aspirin)

Identify goals of therapy.

Goals of therapy
- BP less than 130/80 mm Hg; uncontrolled
- Low-density lipoprotein (LDL) less than 100 mg/dL (coronary artery disease [CAD] risk equivalent; 10-year coronary heart disease [CHD] risk of 30% or greater); uncontrolled
- Successful cessation of smoking
- Reduce/eliminate pain; improve joint function.

Develop a care plan.
- Change dosage regimen: Increase lisinopril to 20 mg once daily.
- Discontinue drug therapy – Ibuprofen
- Initiate new drug therapy – Initiate acetaminophen 1 g orally three times/day for OA.
- Initiate new drug therapy – Simvastatin 40 mg once daily
- Initiate new drug therapy – Aspirin 81 mg once daily
- Initiate new drug therapy – Set a quit date; start nicotine patch (21 mg x 4 weeks; then 14 mg x 2 weeks; then 7 mg x 2 weeks)
- Institute a monitoring plan – Serum creatinine (SCr) and potassium (K+) in 2 weeks for increased lisinopril dose; fasting lipid profile in 6 weeks for simvastatin initiation

Develop a schedule for follow-up.
- Follow up in 2 weeks to assess drug therapy changes and record outcomes.
  i. Draw serum potassium and SCr to monitor increase in lisinopril dose.
  ii. Measure BP to assess the efficacy of the increased lisinopril dose.
  iii. Monitor smoking cessation.
  iv. Monitor adherence to lifestyle modifications.
  v. Monitor for adverse effects of simvastatin.
  vi. Monitor for adverse effects of aspirin.
- Follow up in 6 weeks to assess drug therapy changes and record outcomes.
  i. Draw fasting lipid profile to assess the efficacy of simvastatin.

Evaluate patient outcomes (at follow-up, select category from a list).
HTN: Improved
Dyslipidemia: Partly improved
OA: Worsened
Smoking: Failure

Medication Therapy Management Application

Medication Therapy Review

Medication	Indication	Efficacy	Safety	Adherence	Medication-Related Problem	Priority	Plan
Lisinopril 10 mg once daily	HTN	Poor – BP not controlled Goal BP < 130/80	N/A	Good	Lisinopril dose too low	1	Increase lisinopril dose to 20 mg once daily.
Ibuprofen 400 mg q6h prn pain	OA pain	Still has pain	May ↑ BP; patient taking higher-than-prescribed dose	Take when exercising.	Safety: ibuprofen may be increasing BP; not first line for OA	2	D/C ibuprofen; initiate APAP.
N/A	Smoking cessation				Needs new drug therapy for smoking cessation	2	Initiate nicotine patch.
N/A	New diagnosis of dyslipidemia	N/A Goal LDL < 100; CHD risk equivalent; 10-year CHD risk ≥ 30%	N/A	N/A	Needs new drug therapy for dyslipidemia	1	Initiate simvastatin 40 mg once daily.
N/A	High CV risk; needs aspirin for primary prevention	N/A High CV risk	N/A	N/A	Needs new drug therapy for MI prevention	1	Initiate aspirin 81 mg once daily.

Personal Medication Record (PMR)

(both patient and pharmacist keep one)

Drug and Dose	Take for…	When do I take it?				Start Date	Stop Date	MD	Special Instruct-ions
		AM	Noon	PM	Bed				
Lisinopril 20 mg once daily	High BP	x				x/x/xx		Smith	
Acetaminophen 500 mg 2 tablets 3x/day	OA pain	x	x		x	x/x/xx		Smith	Try to space three doses equally apart.
Simvastatin 40 mg once daily	High cholesterol				x	x/x/xx		Smith	Take in evening.
Aspirin 81 mg once daily	Heart protection	x				x/x/xx		Smith	
Nicotine patch: 21 mg x 4 wk; then 14 mg x 2 wk; then 7 mg x 2 wk	To help quit smoking	x				x/x/xx		Smith	Start on the quit date; do not smoke when using patch; alternate sites.

Medication-Related Action Plan (MAP)
(both patient and pharmacist keep one)

My Medication Action Plan Follow this checklist and make notes of your actions.	
Action Steps: What I Need to Do	Notes: What I Did and When
High BP: Monitor BP at the pharmacy weekly. My goal BP is < 130/80.	x/x/xx: 148/88 x/x/xx: 146/86 x/x/xx: 146/82
OA: Take my acetaminophen regularly.	x/x/xx: Took all three doses x/x/xx: Missed two doses; pain worse x/x/xx: Took all three doses x/x/xx: Missed one dose; pain a little worse
High cholesterol: Take my simvastatin daily and in the evening.	x/x/xx: Missed my dose x/x/xx: Took in the AM accidentally
Smoking cessation: Remember to change my patch weekly. Don't smoke while wearing the patch. Use gum and mints for cravings.	x/x/xx: No cigarettes for a week! x/x/xx: Slipped and had one cigarette

Intervention and/or Referral
Recommendations:

1. Increase lisinopril to 20 mg/day.
2. Discontinue ibuprofen.
3. Start acetaminophen.
4. Start simvastatin.
5. Start aspirin.

Documentation and follow-up:

Follow up in 2 weeks.

a. Draw serum potassium and SCr to monitor increase in lisinopril dose.
b. Measure BP to assess the efficacy of increased lisinopril dose.
c. Monitor smoking cessation.
d. Monitor adherence to lifestyle modifications.
e. Monitor for adverse effects of simvastatin.
f. Monitor for adverse effects of aspirin.

Follow up in 6 weeks.

a. Draw fasting lipid profile to assess the efficacy of simvastatin.

In addition to the previous documentation, a detailed SOAP (subjective, objective, assessment, plan) note must be included in the medical record, and a letter must be sent to the physician (if applicable).

Assessment of patient's medication-related needs

Medication	Indication	Goals of Therapy
Ibuprofen 400 mg po q6h prn pain	OA (knee)	Reduce/eliminate pain. Improve joint function.
Lisinopril 10 mg po once daily	HTN	BP consistently < 130/80 mm Hg

Identify and categorize MRPs.

Medication	MRP	Appropriateness	Effectiveness	Safety	Adherence
Ibuprofen 400 mg po q6h prn pain	2 MRPs Appropriateness Safety	Ibuprofen not first line for OA; not appropriate		Can increase BP, which is uncontrolled; patient is taking higher-than-prescribed dose	Good
Lisinopril 10 mg po once daily	1 MRP Effectiveness		Goal BP < 130/80; not at goal Dose too low		Good
N/A	1 MRP Indication	Not receiving medication for smoking cessation			
N/A	1 MRP Indication	Not receiving medication for dyslipidemia			
N/A	1 MRP Indication	Not receiving medication for MI prevention (high cardiovascular risk)			

Development of a care plan

Indication/Intervention	Goals of Therapy	Plan	Follow-up
HTN	BP < 130/80 mm Hg	Increase lisinopril to 20 mg once daily.	Follow up in 2 weeks: Monitor BP, K, SCr
OA	Reduce/eliminate pain. Improve joint function.	D/C ibuprofen. Start acetaminophen 1 g po tid.	At 2-week follow-up, assess pain control and function.
Smoking cessation	Quit smoking.	Set a quit date. Initiate nicotine patch.	Follow up weekly.
Dyslipidemia	LDL < 100 mg/dL High CHD risk 10-year risk ≥ 30%	Initiate simvastatin 40 mg once daily.	Follow up in 6 weeks. Fasting lipid profile
MI prevention	High CHD risk MI prevention	Initiate aspirin 81 mg once daily.	Yearly

<u>Follow-up</u>
HTN: BP improved; not at goal; laboratory values show safety
Dyslipidemia: Partly improved; not at goal
OA: Worsened
Smoking: Failure; patient did not quit smoking; still smoking 1 pack/day

Society of Hospital Pharmacists of Australia (SHPA) Application

Medication Action Plan	
Interpretation of patient-specific data	BP not well controlled (158/92 mm Hg) Ibuprofen not first line for OA – may increase BP No therapy for smoking cessation Lipid profile shows high LDL. Patient not taking aspirin for MI prophylaxis
Identification of clinical problems	(1) BP uncontrolled on lisinopril 10 mg once daily (MRP: Dose too low) (2) Ibuprofen may be increasing BP, taking higher-than-prescribed dose, not first line for OA (DRP: Adverse reaction) (3) New diagnosis of dyslipidemia; untreated. Needs statin (MRP: Needs additional drug therapy) (4) Wants to quit smoking; needs therapy to help him quit (nicotine patch) (MRP: Needs additional drug therapy) (5) High CAD risk; not taking aspirin; needs aspirin 81 mg once daily (MRP: Needs additional drug therapy)
Establishment of therapeutic goals	HTN BP goal < 130/80 mm Hg (high CAD risk) Dyslipidemia Goal LDL < 100 mg/dL (CHD risk equivalent; 10-year CHD risk ≥ 30%) OA Reduce/eliminate pain; improve joint function Smoking Quit smoking High CAD risk Reduce risk of future MI
Evaluation of therapeutic options AND Individualization of therapy	HTN Lisinopril appropriate first-line antihypertensive therapy Makes sense to titrate vs. add additional therapy Discussed with patient, who agrees Dyslipidemia 46% LDL reduction needed Simvastatin 80 mg/day no longer recommended Options: Simvastatin 40 mg/day, atorvastatin 20 or 40 mg/day, rosuvastatin 5 or 10 mg/day. May get adequate LDL reduction with pitavastatin 4 mg/day, lovastatin 80 mg/day, or pravastatin 80 mg/day. Atorvastatin is generic but still more expensive. Rosuvastatin and pitavastatin not generic Discussed with patient, who agrees OA Acetaminophen first line for OA Patient willing to try acetaminophen Smoking Discuss options for pharmacotherapy to help patient quit smoking. Nicotine replacement is what patient desired. High CAD risk Aspirin 81 mg/day is recommended over other therapies for reducing the risk of MI in patients with a high risk of CAD such as K.G. Patient willing to take
Monitoring of patient outcomes	Monitor for BP control in 2 weeks. ■ Improved; still not at goal BP Monitor K/SCr 1–2 weeks after increase in lisinopril dose. ■ WNL Monitor for pain control and function with acetaminophen. ■ Worsened; OA pain no longer controlled Monitor for efficacy of nicotine replacement once a quit date is determined. ■ Failure; patient did not quit smoking on the quit date Monitor fasting lipid profile in 6 weeks. ■ Partly improved; LDL still not at goal

Accurate medication history

Lisinopril 10 mg orally once daily
Ibuprofen 400 mg orally every 6 hours as needed for pain (taking 2 tablets one to three times/day for 2 years)

Assessment of current medication management

Patient adherent to lisinopril, taking ibuprofen regularly; higher-than-prescribed dose

Clinical review

BP not well controlled (158/92 mm Hg) – Lisinopril dose too low
Ibuprofen not first line for OA – May be increasing BP
No therapy for smoking cessation

Decision to prescribe a medicine

Recommend increasing lisinopril to 20 mg once daily.
Recommend discontinuing ibuprofen.
Recommend starting acetaminophen 1000 mg orally three times/day.
Recommend initiating smoking cessation therapy with nicotine patches.
Recommend initiating simvastatin 40 mg/day.
Recommend initiating aspirin 81 mg/day.

Therapeutic drug monitoring

Monitor for BP control.
Monitor K/SCr 1–2 weeks after increasing lisinopril dose.
Monitor for pain control and function with acetaminophen.
Monitor for efficacy of nicotine replacement once a quit date is determined.
Monitor fasting lipid profile in 6 weeks.

Participation in multidisciplinary ward rounds and meetings – N/A

Provision of medicines information to health professionals

None identified at this time

Provision of medicines information to patients

HTN: Reduce salt intake. Minimize foods high in salt content such as prepared foods, canned soups and vegetables, fast food, and processed food.
Increase moderate-intensity exercise to 30–60 minutes 5 days/week.
Continue reduced-calorie diet and weight loss.

OA: Continue exercises from physical therapist.
Continued weight loss will decrease stress on joints and decrease pain.
Acetaminophen use
Avoid excessive alcohol use.

Smoking cessation: Set a quit date and start patches on this date. It is important not to smoke while taking nicotine patches.
Nicotine patch use
Controlling urges

Information for ongoing care – N/A

Adverse drug reaction management

Lisinopril:	Monitor for development of cough, dizziness, rash, angioedema
Acetaminophen:	Nausea, yellowing of skin or eyes (rare)
Nicotine patches:	Monitor for development of rash, itching, and burning at application site; abnormal dreams, dizziness, sweating
Simvastatin:	Monitor for muscle aches and pains; liver function test monitoring no longer required
Aspirin:	Monitor for signs and symptoms of GI bleeding.

Individualized Medication Assessment and Planning (iMAP) Application

Review and synthesize information from medical record.
- Lisinopril 10 mg orally once daily for HTN
- Ibuprofen 400 mg orally every 6 hours as needed for OA

Conduct comprehensive medication review with patient.
- Lisinopril – Using as prescribed, good adherence
- Ibuprofen – Taking higher-than-prescribed dose: 2 tablets one to three times/day for 2 years

Identify MRPs.
(1) Suboptimal dosing: Lisinopril; goal BP less than 130/80; BP not controlled
(2) Suboptimal drug: Ibuprofen not first line for OA and may be increasing BP
(3) Drug therapy needed: Needs drug therapy for new diagnosis of dyslipidemia (statin); goal LDL less than 100 mg/dL
(4) Drug therapy needed: Needs drug therapy for smoking cessation
(5) Drug therapy needed: Needs drug therapy for MI prevention (aspirin)

Formulate assessment/propose plan to optimize medication use.
- Recommend increasing lisinopril to 20 mg once daily.
- Recommend discontinuing ibuprofen.
- Recommend starting acetaminophen 1 g orally three times/day.
- Recommend starting simvastatin 40 mg once daily.
- Initiate nicotine replacement therapy with patch once a quit date is set.
- Recommend starting aspirin 81 mg once daily.

Communicate proposed plan to primary care provider.
- Discussed all recommendations with Dr. Smith, who agreed; OR
- Plan is according to collaborative practice agreement in place with Dr. Smith.

Implement plan once consensus is reached.
- Call in/write prescription for new lisinopril dose, acetaminophen, simvastatin, aspirin according to collaborative practice agreement or verbal order; Dr. Smith

Educate patient.
- Provided written medication list with all medications and changes noted
- Educated patient on proper use of all new medications
- Educated patient on adverse effects of new medications to watch out for
- Set a quit date and start patches on this date. Educated patient not to smoke with nicotine patches
- Discussed controlling urges, coping with cravings, and dealing with triggers for smoking

Document plan in medical record and provide written summary to patient.
- SOAP note written in medical record
- Written medication list and summary of plan given to patient

Reconcile medications at all encounters, including transitions of care.

Provide ongoing face-to-face and telephone follow-up.
Follow up in 2 weeks.
1. Draw serum potassium and SCr to monitor increase in lisinopril dose.
2. Measure BP to assess the efficacy of the increased lisinopril dose.
3. Monitor success with smoking cessation.
4. Monitor adherence to lifestyle modifications.
5. Monitor for adverse effects of simvastatin.
6. Monitor for adverse effects of aspirin.

Follow up in 6 weeks.
1. Draw fasting lipid profile to assess the efficacy of simvastatin.
2. Monitor success with smoking cessation.

Acute Care Patient Case Example

CC: J.B. presents to the emergency department with altered mental status, "yellow skin," and increased abdominal distension; also, she is vomiting blood.

HPI: J.B. is a 44-year-old white woman with a known history of alcohol abuse for 20 years. She was given a diagnosis of cirrhosis 1 year ago.

Medical History: Alcoholic cirrhosis x 1 year
HTN x 1 year

Medication History:
Allergies: NKDA
Current medications (nonadherent, according to family):
Lactulose 30 mL orally twice daily
Lisinopril 10 mg orally daily

Family History:

Father:	Living; HTN, diabetes mellitus (DM)
Mother:	Died of "liver disease because of drinking"
Brother:	Living; alcoholic

Social History:

Tobacco:	None
Alcohol:	Drinks 12 beers per day and 750 mL of vodka on weekends
Diet:	Doesn't eat much

ROS/Physical Examination:
HEENT: (+) Icteric sclera
CV: No CP, no palpitations, tachycardic
Pulm: (+) SOB; crackles heard at lung bases
GI: (+) Abdominal distension; (+) black stools; (+) bloody vomit
Skin: Jaundiced, (+) spider angiomata

Vital Signs:
BP: 100/70
HR: 110; RR: 18; Temp: 99.0; Ht: 5′6″; Wt: 110 lb

Pharmaceutical Care Application

Collect patient-specific information (as previously summarized).

Includes Pharmacotherapy Workup

In this interprofessional setting, the review of systems by the pharmacist is not necessary, as it was already done by the physician. The Pharmacotherapy Workup also includes asking the patient about his or her existing medical conditions to determine what conditions exist. In a setting such as a community pharmacy, this would be important, but in this setting, it is not necessary because all the medical conditions are already in the medical record.

Analyze clinical data (reported below).

Identify drug-related problems.

- Indication: Needs additional drug therapy for esophageal varices
- Indication: Needs additional drug therapy for hyperammonemic hepatic encephalopathy
- Indication: Needs additional drug therapy for ascites

Laboratory Data:

		Normal Range
Na	130 mEq/L	135–145
K	3.0 mEq/L	3.5–5.0
Cl	90 mEq/L	96–106
CO_2	30 mmol/L	22–28
BUN	6 mg/dL	8–20
Cr	0.4 mg/dL	0.7–1.5
Glu	86 mg/dL	70–110
AST	60 U/L	4–36
ALT	30 U/L	4–36
Tbili	8.1 mg/dL	0.3–1.0
Alk Phos	150 U/L	30–120
Albumin	2.1 g/dL	3.2–4.8
PT/INR	19/1.16	
WBC	4500/mm^3	5000–10,000
Hb	7.9 g/dL	12–16
HCT	21%	37–47
Plt	82/mm^3	150,000–400,000
Ammonia	150 mcg/dL	10–80

Imaging:
Chest x-ray (CXR): Bibasilar pulmonary edema
Abdominal ultrasonography (U/S): Nodular liver and splenomegaly; marked ascites
Esophagogastroduodenoscopy: Two bleeding esophageal varices were found and sclerosed.

Identify the goals of therapy.

Goals of therapy (and list if controlled or uncontrolled)

- BP less than 140/90; controlled without therapy (not taking lisinopril)
- Promote excretion of ammonia; uncontrolled
- Decrease pressure in the portal vein; uncontrolled
- Decrease fluid accumulation in the abdomen; uncontrolled
- Stop the use of alcohol; prevent delirium tremens; not yet achieved

Develop a care plan.

- Initiate new drug therapy (for bleeding esophageal varies) – once hemodynamically stable: propranolol 20 mg orally twice daily
- (Re)initiate new drug therapy (for hyperammonemic hepatic encephalopathy) – Lactulose 30 mL orally every 8 hours; adjust the dose to achieve two or three stools per day
- Initiate new drug therapy (for ascites) – After paracentesis: spironolactone 50 mg orally daily plus furosemide 20 mg orally daily
- Initiate new drug therapy for alcohol cessation (for delirium tremens prophylaxis) – Lorazepam as needed
- Unnecessary drug therapy – Discontinue lisinopril.

Develop schedule for follow-up.
Follow up in 24 hours to assess drug therapy changes and record outcomes.

- Vital signs
- Stool count
- Electrolytes
- Mental status

Evaluate patient outcomes (at follow-up, select category from a list).

- HTN: Controlled
- Esophageal varices: Partly improved
- Hyperammonemic hepatic encephalopathy: Improved
- Ascites: Partly improved

Medication Therapy Management Application

Medication Therapy Review

Medication	Indication	Efficacy	Safety	Adherence	Medication-Related Problem	Priority	Plan
Lisinopril 10 mg po daily	HTN	Good – BP 100/70 Goal < 140/90	N/A	Nonadherent	None		Discontinue
Lactulose 30 mL po bid	Hepatic encephalopathy	Uncontrolled; goal: promote excretion of ammonia	N/A	Nonadherent	Nonadherence	1	Reinitiate and increase dose to 30 mL q8h; adjust to achieve 2 or 3 stools/day.
N/A	Esophageal varices	Uncontrolled; decrease pressure in the portal vein	N/A		Needs new drug therapy	1	Initiate propranolol 20 mg bid
N/A	Ascites	Uncontrolled; decrease abdominal fluid accumulation	N/A		Needs new drug therapy	1	Initiate spironolactone 50 mg po daily plus furosemide 20 mg po daily.

Personal Medication Record (PMR) and Medication-Related Action Plan (MAP)

These elements are not applicable while the patient is in the hospital, as the medications will be given in the hospital and then may be changed at discharge. In addition, the PMR and MAP are meant for the patient to follow and use at home; in the hospital, the patient is not responsible for his or her own medications. A PMR and an MAP may be given to the patient at discharge, but they may be different from the medications that are started initially while in the hospital.

Intervention and/or referral
Recommendations:

1. Discontinue lisinopril.
2. Reinitiate lactulose and increase dose to 30 mL every 8 hours; adjust to achieve two or three stools per day.
3. Start propranolol.
4. Start spironolactone and furosemide.

Documentation and follow-up:

- Follow up in 24 hours to assess drug therapy changes and record outcomes.
  - Vital signs
  - Stool count
  - Electrolytes
  - Mental status

Depending on whether pharmacist chart documentation privileges are available at your institution, a SOAP note may or may not be left in the chart.

Assessment of patient's medication-related needs

Medication	Indication	Goals of Therapy
Lisinopril 10 mg po daily	HTN	BP consistently < 140/90 mm Hg
Lactulose 30 mL po bid	Hepatic encephalopathy	2 or 3 stools/day

Identify and categorize MRPs.

Medication	MRP	Appropriateness	Effectiveness	Safety	Adherence
Lisinopril 10 mg po daily	1 MRP Indication	Not indicated, as BP is controlled while not taking	N/A; patient not taking; BP 100/70	No ADRs noted	Poor
Lactulose 30 mL po bid	1 MRP Adherence	Appropriate	N/A; patient not taking – Patient has elevated ammonia level and altered mental status.	No ADRs noted	Poor
N/A	1 MRP Indication	Not receiving medication for bleeding esophageal varices	N/A	N/A	N/A
N/A	1 MRP Indication	Not receiving medication for ascites	N/A	N/A	N/A

Development of a care plan

Indication/Intervention	Goals of Therapy	Plan	Follow-up
HTN	Maintain BP < 140/90 mm Hg	Discontinue lisinopril, and initiate other therapy below.	Check daily to ensure BP is appropriate.
Hepatic encephalopathy	Promote excretion of ammonia.	Continue lactulose 30 mL; increase to q8h.	Check daily to ensure patient is having 2 or 3 stools/day. Monitor mental status and ammonia level (as needed). If the patient is meeting the goal stools/day and the ammonia level has decreased, yet is still encephalopathic, consider other pharmacotherapy.
Esophageal varices	Decrease pressure in the portal vein.	Initiate propranolol 20 mg po bid once the patient is stable.	Monitor the patient's BP and HR daily.
Ascites	Decrease fluid accumulation in the abdomen.	Begin therapy after paracentesis with spironolactone 50 mg po daily plus furosemide 20 mg po daily.	Monitor BP and fluid output daily.
Alcohol cessation	Stop the use of alcohol; prevent delirium tremens.	When patient is medically stable, discuss with her the importance of stopping alcohol. Patient may need prn lorazepam.	May need referral to Alcoholics Anonymous for support in maintaining abstinence

Follow-up

HTN: Controlled
Bleeding esophageal varices: Partly improved
Hyperammonemic hepatic encephalopathy: Improved
Ascites: Partly improved

Medication Action Plan	
Interpretation of patient-specific data	Patient is somewhat hypotensive (100/70 mm Hg) while not taking lisinopril. Patient is nonadherent to lactulose; has encephalopathy, with an elevated ammonia level Patient has esophageal varices and is not taking a nonselective β-blocker. Patient has ascites and is not taking an aldosterone antagonist. Patient is alcoholic and is not on therapy to prevent alcohol withdrawal/delirium tremens.
Identification of clinical problems	(1) Lisinopril unnecessary; BP low and patient not taking it (MRP: Needs additional drug therapy) (2) Patient has altered mental status and an elevated ammonia level; not adherent to lactulose therapy; goal 2 or 3 BMs/day. (MRP: Nonadherence) (3) Needs therapy for esophageal varices (MRP: Needs additional drug therapy) (4) Needs therapy for ascites (MRP: Needs additional drug therapy) (5) Needs therapy for alcohol withdrawal/delirium tremens prophylaxis (MRP: Needs additional drug therapy)
Establishment of therapeutic goals	Goals: BP goal < 140/90 mm Hg Promote excretion of ammonia; 2 or 3 BMs/day; uncontrolled Decrease pressure in the portal vein; uncontrolled Decrease fluid accumulation in the abdomen; uncontrolled Stop the use of alcohol; prevent delirium tremens; not yet achieved
Evaluation of therapeutic options AND Individualization of therapy	Hypertension Lisinopril appropriate but not necessary because patient is hypotensive and propranolol is being initiated Discussed with patient's family, who agrees Esophageal varices Nonselective β-blocker is needed. Options: Propranolol, carvedilol, and nadolol Discussed with patient's family, who agrees to try propranolol Ascites Patient not currently taking therapy for ascites. Combination of furosemide and spironolactone is recommended. Patient must be stable first, and paracentesis should be done initially. Discussed with patient's family, who agrees Alcoholism Patient needs to stop alcohol use; family agrees. Needs prn benzodiazepine to prevent delirium tremens Discussed with family, who agrees
Monitoring of patient outcomes	Follow up in 24 hours to assess drug therapy changes and record outcomes. ■ Vital signs • BP stable; no hypotension ■ Stool count • 2 or 3 stools/day ■ Electrolytes and fluid status • WNL; ascites partly improved ■ Mental status • Improved

Accurate medication history

Lisinopril 10 mg/day orally

Lactulose 30 mL orally twice daily

Assessment of current medication management

Patient nonadherent to lisinopril and lactulose

Clinical review
- Patient is somewhat hypotensive (100/70 mm Hg), and propranolol is being initiated – Patient is not taking lisinopril.
- Patient is nonadherent to lactulose; has encephalopathy, with an elevated ammonia level
- Patient has esophageal varices and is not taking a nonselective β-blocker.
- Patient has ascites and is not taking an aldosterone antagonist.
- Patient is an alcoholic and is not on therapy to prevent alcohol withdrawal/delirium tremens.

Decision to prescribe a medicine
- Recommend discontinuing lisinopril.
- Recommend initiating lactulose 30 mL orally every 8 hours.
- Recommend initiating propranolol 20 mg orally twice daily once she is deemed clinically stable.
- Recommend initiating spironolactone 50 mg orally daily once she is deemed clinically stable after paracentesis.
- Recommend initiating furosemide 20 mg orally daily once she is deemed clinically stable after paracentesis.
- Recommend initiating lorazepam for delirium tremens prophylaxis.

Therapeutic drug monitoring

Monitor BP and HR.
Monitor K/SCr daily while hospitalized and then in 1–2 weeks after discharge.
Monitor mental status and bowel movements (goal is two or three while taking lactulose).
Monitor urine output.

Participation in multidisciplinary ward rounds and meetings

Monitor the patient, as above, to optimize pharmacotherapy.
Round with the medical team and provide recommendations.

Provision of medicines information to health professionals

None needed at this time

Provision of medicines information to patients

This is not as applicable in a hospital setting. The patient can be educated on the acute medications that are being initiated while in the hospital and what they are being used for. When patients are discharged, information about their medicines should be provided to them, but these medicines may be different from what was used acutely in the hospital.

Information for ongoing care – N/A

Adverse drug reaction management

Lactulose:	Monitor for hypokalemia and signs of dehydration.
Propranolol:	Monitor HR/BP for hypotension/bradycardia.
Spironolactone:	Monitor for hyperkalemia and elevations in SCr.
Furosemide:	Monitor for hypokalemia and elevations in SCr. Monitor for tinnitus/hearing impairment.
Lorazepam:	Monitor for oversedation. Monitor for respiratory depression and hypotension.

Individualized Medication Assessment and Planning (iMAP) Application

Review and synthesize information from medical record.
- Lisinopril 10 mg/day orally for HTN
- Lactulose 30 mL orally twice daily

Conduct a comprehensive medication review with patient.
- Patient is altered, so an interview is not useful. According to family, the patient is nonadherent to the currently prescribed medications and is currently not taking any medications.

Identify MRPs.

(1) Suboptimal drug: Lisinopril unnecessary; goal BP less than 140/90; BP low and patient not taking it
(2) Nonadherence: Patient has altered mental status and an elevated ammonia level; nonadherent to lactulose therapy; goal two or three bowel movements daily
(3) Drug therapy needed: Needs therapy for esophageal varices
(4) Drug therapy needed: Needs therapy for ascites
(5) Drug therapy needed: Needs therapy for alcohol withdrawal/delirium tremens prophylaxis

Formulate assessment/propose plan to optimize medication use.

- Recommend discontinuing lisinopril.
- Recommend reinitiating lactulose and increasing dose to every 8 hours.
- Recommend starting propranolol 20 mg orally two times/day once the patient is hemodynamically stable.
- Recommend starting spironolactone 50 mg orally daily plus furosemide 20 mg orally daily after paracentesis.
- Recommend starting lorazepam as needed.

Communicate proposed plan to primary care provider.

- Discussed all recommendations with Dr. Smith, who agreed

Implement plan once consensus reached

- Verbal orders given for all of the medication changes, per Dr. Smith

Educate patient.

- Unable to do at this time because of mental status
- Family educated on medications initiated in the hospital
- Patient educated on discharge from hospital regarding discharge medications

Document plan in medical record and provide written summary to patient.

- SOAP note

Reconcile medications at all encounters, when possible, including transitions of care.

- Medications reconciled at hospital admission; as above

Provide ongoing face-to-face and telephone follow-up.

- With physician and patient's family, unable to communicate with patient
- Follow up in 24 hours to assess drug therapy changes and record outcomes.
  - Vital signs
  - Stool count
  - Electrolytes
  - Mental status

In part IV, next month's final entry in this commentary series, we will present a "composite" clinical pharmacy practice model for ACCP member discussion and feedback. This feedback will be sought (1) through an online member survey to be made available in mid-September and (2) during the 2012 Annual Town Hall Meeting in Hollywood, Florida, on October 21. This will be your opportunity to voice your views on whether organized clinical pharmacy should promote a consistent patient care process that can be implemented in any practice setting and, if your answer is "yes," what type of model should be considered. Your opinions will be essential to the process that will determine the College's ultimate answer to this question.

[a]Committee members: Ila Harris (chair), Beth Phillips (vice chair), Eric Boyce, Sara Griesbach, Charlene Hope, Denise Sokos, and Kurt Wargo.

Baker, Farland, and Patanwala to Receive ACCP Honors

ACCP members William L. Baker, Michelle Z. Farland, and Asad Patanwala were selected by the 2012 ACCP Awards Committee to receive the College's prestigious 2012 New Investigator, New Educator, and New Clinical Practitioner Awards, respectively. The awards will be presented in Hollywood, Florida, on Monday, October 22, 2012, at 9:15 a.m. during a special session of the 2012 ACCP Annual Meeting.

The New Investigator Award recognizes an ACCP member who has made a significant impact on an aspect of clinical pharmaceutical science. The awardee must have been a member of ACCP for more than 3 years; must have completed his or her terminal training or degree less than 6 years previously; and must have a research program with a substantial publication record that includes a programmatic theme or an especially noteworthy single publication. William L. Baker Jr, Pharm.D., BCPS (AQ Cardiology), is an assistant professor of pharmacy practice at the University of Connecticut School of Pharmacy and a clinical specialist in internal medicine at the University of Connecticut Health Center. He also serves as a senior research scientist at the University of Connecticut/Hartford Hospital Evidence-Based Practice Center in Hartford, Connecticut. Dr. Baker's research focuses on cardiovascular medicine and comparative effectiveness. At the time of his nomination, Dr. Baker had published 38 peer-reviewed research papers. His articles have been published in high-impact journals including *Annals of Internal Medicine, Diabetes Care*, *Journal of Hypertension*, and *Journal of the American Geriatrics Society*, as well as *Pharmacotherapy*, *The Annals of Pharmacotherapy*, and others. In addition, Dr. Baker has written 23 review articles, 3 case reports, and 2 book chapters. He has served as the primary investigator (PI) on several projects focused on cardiovascular therapeutics or comparative effectiveness, including a $200,000 federally funded grant from the Agency for Healthcare Research and Quality, and five non-federally funded projects totaling more than $414,000. Although his work has been largely devoted to cardiovascular-related issues, one of his nominators called attention to the breadth of his comparative effectiveness research:

> Dr. Baker has engaged in several funded projects on the impact of ACE inhibitors or ARBs on cardiac outcomes, the impact of medications on movement disorders, and the impact of medications on psoriasis. These projects center on determining comparative effectiveness and his contributions are strong. In summary, Dr. Baker has established a wonderful research program that has answered numerous research questions.

Dr. Baker will deliver the annual New Investigator Award Lecture during the October 21 Special Session in Hollywood.

The ACCP New Educator Award is given to recognize and honor a new educator for outstanding contributions to the discipline of teaching and to the education of health care practitioners. The awardee must have been a Full Member of ACCP at the time of nomination and a member at any level for a minimum of 3 years; in addition, the awardee must have completed his or her terminal training or degree less than 6 years previously. Michelle Z. Farland, Pharm.D., BCPS, CDE, is an assistant professor in the Department of Clinical Pharmacy at the University of Tennessee College of Pharmacy, Knoxville campus, where she also serves as a clinical specialist in Ambulatory Care. Dr. Farland serves as course codirector in two required courses and course director for an elective course in the university's Pharm.D. curriculum. She also precepts a full cadre of Pharm.D. students, as well as PGY1 and PGY2 residents, in ambulatory care throughout the year. Dr. Farland has been a leader in implementing team-based learning within the University of Tennessee Health Science Center. In her role as a course codirector, she has incorporated many innovations. University of Tennessee Associate Dean Debbie Byrd commented in her letter of support,

> The required courses are taught via synchronous videoconference distance education between our Memphis and Knoxville campuses, and Dr. Farland coordinates these courses with her co-directors on the Memphis campus. Despite the distance, and her status as a junior faculty member, she has successfully transformed the Medication Therapy Management (MTM) course's content and teaching methods. She has incorporated pharmacy residents in this course as well, introducing them to more active Team Based Learning (TBL) and giving them the opportunity to develop their own teaching skills as future educators.

One of Dr. Farland's students in the MTM course was quoted as saying,

> [MTM] recitation really helped with making me change my way of thinking when looking at patients…. I find myself constantly in MTM mode when at work and I completely enjoy it.

Dr. Farland has also become engaged in the scholarship of teaching through publication in the *American Journal of Pharmaceutical Education* and presentations of her work at several annual meetings of the American Association of Colleges of Pharmacy.

The New Clinical Practitioner Award honors a new clinical practitioner who has made outstanding contributions to the health of patients and/or the practice of clinical pharmacy. The awardee must have been a Full Member of ACCP at the time of nomination, as well as a member at any level for a minimum of 3 years; in addition, the awardee must have completed his or her terminal training or degree less than 6 years previously. Asad (Sid) Patanwala, Pharm.D., BCPS, is a clinical assistant professor of pharmacy practice and science and a clinical pharmacy specialist in emergency medicine at the University of Arizona Medical Center in Tucson, Arizona. Shortly after assuming his faculty position, Dr. Patanwala developed a new service within the emergency department (ED) at University Medical Center. He initiated a direct patient care and consult service for the ED staff, including nurses, residents in training, and attending staff. This on-site pharmacist activity now provides direct consultation to patients in the ED for more than 50 hours a week. In addition, the program works with the Pharmacy and Therapeutics Committee of University Medical Center regarding ED-related medication issues, including evaluation of new pharmaceutical agents and development of a revised computerized physician order entry set to improve patient safety. Dr. Harvey Meislin, head of the University Medical Center's ED, wrote in his letter of support for Dr. Patanwala's nomination,

> Overall, this program that has been initiated by Dr. Patanwala has become an essential part of the daily practice of emergency medicine in a very busy level one trauma center. The relationship between physicians and pharmacists has never been better; we constantly depend on one another. This relationship has extended into both the academic and research environment. As I understand it, the new clinical practitioner award is to recognize and honor a new clinical practitioner who has made outstanding contributions to the health of patients and/or the practice of clinical pharmacy. Dr. Patanwala meets every aspect of this award. As the department head of Emergency Medicine for more than 30 years, the involvement of the emergency pharmacy program has made a contribution unlike any other.

Dr. Patanwala has published and presented on the impact of ED clinical pharmacist contributions to improving patient safety and reducing medication errors, including presentations at the Annual Meeting of the American College of Emergency Physicians and publications in the *Annals of Emergency Medicine* and the *Journal of Opioid Management*.

The members of the 2012 ACCP Awards Committee were Mark Garrison (chair), Robert MacLaren (vice chair), Catherine Crill, Leslie Hamilton, Dwight Kloth, Molly Leber, Shawn McFarland, Judith Smith, James Tisdale, and Nathan Wiederhold.

Attention Students: Want to Maximize Your Ability to Secure a Residency Position? Attend a Unique ACCP Program for First-, Second-, and Third-Year Students

Are you planning to complete a residency after graduation? You probably know that of the more than 4200 applicants who participated in the ASHP Resident Matching Program in 2012, about 38% did not match with a program.[1] As competition among residency applicants continues to increase, it is important that students know the types of candidates that residency programs look for and learn the steps that students can take now to distinguish themselves from the crowd.

Make plans now to join ACCP in Hollywood, Florida, this October for an informative and interactive program titled "Emerge from the Crowd: How to Become a Standout Residency Candidate." This unique program, a premeeting symposium that will be held before the 2012 ACCP Annual Meeting, is designed to help first-, second-, and third-year pharmacy students maximize their ability to secure a residency position upon graduation.

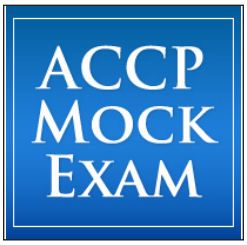
Students who attend "Emerge from the Crowd" will receive 7 hours of interactive programming on Friday, October 19, 2012, at The Westin Diplomat Resort. Additional student programming and the Clinical Pharmacy Challenge will be held during the ACCP Annual Meeting, which begins on Saturday, October 20, in the same location (note: the Annual Meeting requires a separate registration).

From experts in the field of clinical pharmacy, students will learn the steps they can take now to rise above the competition when applying for a residency during their final academic year. Topics will include maximizing classroom and experiential education, networking, becoming involved in professional organizations, developing leadership skills, developing CVs and portfolios, and engaging in scholarly activity. Attendees will also have the opportunity to sit down face-to-face with current residents and residency program directors to gain from their perspectives and advice during a special roundtable session.

Registration is now open. For more information, visit www.accp.com/stunet.

[1]American Society of Health System Pharmacists. ASHP Resident Matching Program, 2012. Available at www.natmatch.com/ashprmp/. Accessed July 30, 2012.

2012 ACCP Pharmacotherapy Mock Examination Now Available



ACCP proudly introduces a new way to study for the Pharmacotherapy Specialty Examination with the ACCP Pharmacotherapy Mock Exam. The ACCP 2012 Pharmacotherapy Mock Exam is a 200-item question bank based on the content and domains in the Board of Pharmacy Specialties (BPS) content outline, which provides you online access anywhere and anytime for 12 months. In addition, you can take the exam as many times as you wish within those 12 months. Purchase the Mock Exam at www.accp.com/bookstore/meph12.aspx by August 31 and receive a discount of up to 25% off the regular price (see below)!

Enhance Your Studying

Developed and reviewed by board-certified clinical pharmacists, the ACCP Pharmacotherapy Mock Exam provides specific feedback customized to each individual participant. This feedback includes how much time is spent on each question and what types of questions are most frequently missed by the participant, as well as an answer key that contains explained answers and/or references for further study. This tool is ideal for anyone who has been studying for the Pharmacotherapy board examination and wants to learn more about his or her potential strengths and weaknesses in preparing for the examination in October.

Take Advantage of Discount Pricing Until August 31

For a limited time only, save up to $20 off the regular price of the ACCP Pharmacotherapy Mock Exam. Purchase the mock exam by August 31, 2012, to receive this introductory discounted price. The ACCP Pharmacotherapy Mock Exam is only $49.95 for anyone who attended the ACCP Updates in Therapeutics® 2012 live course or who purchased an ACCP Updates in Therapeutics® 2012 product. The cost is $79.95 for all other ACCP members and $189.95 for nonmembers. Prices will increase on September 1, 2012. Purchase now at www.accp.com/bookstore/meph12.aspx for maximum savings.

Please note: Although clinical pharmacy specialists familiar with the Pharmacotherapy specialty have assisted in developing the ACCP Pharmacotherapy Mock Exam, none of these individuals has served on a BPS Specialty Council or as an item writer for BPS.

ACCP Elects 2012 Fellows

Nineteen ACCP members have been elected Fellows of the American College of Clinical Pharmacy and will be recognized during a special ceremony on October 21 at the College's 2012 Annual Meeting in Hollywood, Florida. Recognition as a Fellow is awarded to ACCP members who have demonstrated a sustained level of excellence in clinical pharmacy practice and/or research. Fellows can be recognized by the initials "FCCP" as part of their title.

The 2012 ACCP Fellows are:

David Baribeault, B.S.; Salem, MA
Amie Brooks, Pharm.D.; St. Charles, MO
Krystal Edwards, Pharm.D.; Dallas, TX
Shareen El-Ibiary, Pharm.D.; Glendale, AZ
Brian Hemstreet, Pharm.D.; Aurora, CO
Kellie Jones, Pharm.D.; Indianapolis, IN
Kristi Kelley, Pharm.D.; Vestavia Hills, AL
W. Klugh Kennedy, Pharm.D.; Savannah, GA
Ty Kiser, Pharm.D.; Aurora, CO
Julie Kissack, Pharm.D.; Searcy, AR
Ishaq Lat, Pharm.D.; Chicago, IL
Julie Murphy, Pharm.D.; St. Charles, MO
Ruth Nemire, Pharm.D., B.S.; Plantation, FL
Toni Ripley, Pharm.D.; Edmond, OK
J. Mark Ruscin, Pharm.D.; Springfield, IL
Nicole Sifontis, Pharm.D.; Philadelphia, PA
Gregory Smallwood, Pharm.D.; Suwanee, GA
Nathan Wiederhold, Pharm.D.; San Antonio, TX
Susan Winkler, Pharm.D.; Downers Grove, IL

After nomination by their colleagues, Fellow candidates undergo a comprehensive and rigorous evaluation by the Credentials: Fellowship Committee of their practice and research accomplishments. Among the criteria evaluated by the committee are examples of patient care service or educational programs developed by the nominee; certifications or other credentials earned; drug therapy management responsibilities; educational presentations; consultantships; service to publications; original research presentations, projects, funding, and publications; and other professional activities and awards. Individuals nominated as Fellows also must have made a substantial contribution to ACCP through activities such as giving presentations at College-sponsored meetings; providing service as an abstract, curriculum vitae, ACCP Clinical Pharmacy Challenge, Research Institute, or *Pharmacotherapy* reviewer; contributing to College publications or being an item writer for the ACCP Clinical Pharmacy Challenge; serving as a committee member; or completing a term as a Practice and Research Network, chapter, or other elected ACCP officer.

Members of the 2012 Credentials: Fellowship Committee, each of whom dedicated many hours to the review of FCCP applications and other documents, were David Allen, Miranda Andrus, Jacque Bainbridge, Steven Barriere, Melissa Blair, David Burgess (vice chair), Sheryl Chow, Jeffrey Delafuente, Christopher Destache, Lori Dickerson, Paul Dobesh, Mary Ensom, Mark Haase, Mary Hayney, Daniel Healy, Joanna Hudson, Melanie Joy, Gary Levin (chair), David Lourwood, James Lyon, Margaret Noyes Essex, Mary Beth O'Connell, Beth Resman-Targoff, Melody Ryan, James Scott, Marisel Segarra-Newnham, Larry Segars, Amy Seybert, Nancy Shapiro, Maureen Smythe, Eva Vasquez, and Dan Wermeling.

2012 Annual Meeting Offers a Full Complement of Curricular Tracks and PRN Programming

ACCP's 2012 Annual Meeting, to be held October 21–24 in Hollywood, Florida, promises a high-quality lineup of educational programs, with topics ranging from emerging therapies to expanding the role and influence of clinical pharmacists. Start building your Annual Meeting educational itinerary around the meeting's three curricular tracks—each offering sessions designed to deliver in-depth, clinically relevant information.

Curricular Track I—Expanding the Role of Pharmacists in Ensuring Optimal Healthcare Outcomes will review examples of successful models of pharmacists ensuring optimal transitions of care and address challenges to implementing pharmacist involvement in such activities. This track will also identify the role of pharmacists in implementing quality measures in the inpatient and outpatient setting to ensure optimal prescribing; describe the impact of the pharmacist and medication management on implementing the patient-centered medical home; and provide examples of successful models of practice in the private and public sectors.

Curricular Track II—Developing New Corridors to Grow the Future of Pharmacy will identify how to use a practice-based research network to successfully conduct research in a busy clinical practice setting, discuss successful stories of obtaining grant funding through the Future Investigators Training Program, and describe how to integrate clinical pharmacy into clinical decision support systems. This track will also identify methods to grow residency training programs and provide models to incorporate the growing number of learners into expanded clinical pharmacy services.

Curricular Track III—Addressing Controversies in the Management of Chronic Diseases will evaluate evidence for new anticoagulant and antiplatelet agents and the appropriate use of these agents in lieu of more traditional therapies. In addition, this track will review evidence for new drug therapies and the use of drug holidays in osteoporosis management. This track will

also address controversies surrounding the management of patients with diabetes in both the inpatient and outpatient setting.

PRNs Provide Focused Education and Networking Sessions

In addition to these curricular tracks, ACCP's Practice and Research Networks have developed focus sessions that provide the latest information and developments in a variety of therapeutic and practice areas. For a complete schedule of Annual Meeting educational activities, visit the ACCP Web site at www.accp.com/am.

Annual Meeting attendees will also have access to PRN Business Meetings and Networking Forums, scientific poster and platform presentations, industry exhibits, and the final rounds of the ACCP Clinical Pharmacy Challenge for students. To register for the 2012 ACCP Annual Meeting and make hotel reservations, visit www.accp.com/am. Register early for maximum savings—the early registration deadline is September 14, 2012.

ACCP Academy Programming at the 2012 Annual Meeting

Plan now to attend ACCP Academy programming at the 2012 ACCP Annual Meeting, October 21–24, in Hollywood, Florida. The ACCP Academy provides four unique professional development programs leading to certificates of completion in Career Advancement (formerly Clinical Practice Advancement), Leadership and Management, Research and Scholarship, and Teaching and Learning. The foundational prerequisite courses for the Teaching and Learning program and the Career Advancement program, as well as a required course for the Research and Scholarship program, will be presented as premeeting symposia on Saturday, October 20. A separate registration fee is required to attend any of these sessions.

ACCP Academy programming during the Annual Meeting will include both required modules and elective courses, according to preestablished course schedules. Additional sessions, including Leadership and Management courses, are included in the Annual Meeting registration fee. An abbreviated schedule of Academy programming, including both presymposia and programming embedded in the Annual Meeting, is summarized below. For a full programming schedule, consult the ACCP Web site at www.accp.com/am.

ACCP Annual Meeting Academy Schedule

Academy	Courses	Schedule
Career Advancement	Career Advancement Primer (prerequisite)*	October 20
	Education and Training PRN Focus Session—Residency Program Director Development: Survival Skills for New Directors (elective)***	October 22
	Clinical Career Advancement, Part I	October 22
	Clinical Career Advancement, Part II	October 23
	Enhancing Clinical Outcomes Through Application of the Breakthrough Model of Performance Improvement (elective)	October 23
Teaching and Learning	Basic Training for New Clinical Faculty and Preceptors (prerequisite)*	October 20
	Reflective Writing as a Teaching Strategy (elective)	October 22
	Implementing Teaching and Learning Strategies	October 22
	Learning Crisis: Helping APPE Students to Be Effective in Difficult Situations (elective)	October 23
Research and Scholarship	Regulatory/Ethical Issues*	October 20
	Curricular Track II: Developing New Corridors to Grow the Future of Pharmacy—Clinical Pharmacy Research – Addressing Everyday Challenges (elective)**	October 22
	Basics of Clinical Research	October 22
	Pharmaceutical Industry PRN Focus Session: Rationale for and Application of Novel Trial Design in Clinical Research (elective)***	October 23
Leadership and Management	Life Balance and Well-being (elective)	October 22
	Education and Training PRN Focus Session—Residency Program Director Development: Survival Skills for New Directors (elective)***	October 22
	Personal Leadership Development	October 23
	The Attributes of a Leader	October 24

* *Offered as presymposia. Separate registration required.*
** *Developed by the 2012 Annual Meeting Program Committee and approved for elective credit.*
*** *Developed by an ACCP Practice and Research Network and approved for elective credit.*

To register for the 2012 ACCP Annual Meeting and make hotel reservations, visit www.accp.com/am. Register early for maximum savings—the early registration deadline is September 14, 2012.

To learn more about each certificate program and to enroll online, visit the ACCP Academy Web page at www.accp.com/academy. A one-time application fee of $150.00 (to offset expenses for online portfolio maintenance) will be charged upon enrollment in the certificate program.

Let ACCP Enhance Your Recruitment Efforts

Recruiting the candidate you want can be time-consuming and costly, but ACCP can make it easier. The College provides a variety of advertising options designed to reach highly qualified clinical pharmacy specialists and trainees at an affordable price. The ACCP Career Center, available online at www.accp.com/careers, provides detailed information on various effective recruiting options, including the following:

- *Online Position Listings*—Whether you're looking for a seasoned professional or seeking to promote future residency and fellowship positions, the ACCP online position listings can be tailored to fit your needs. Listing a regular position online is only $175 for ACCP members, and if you're listing a residency or fellowship, the cost is only $75. Moreover, through the ACCP Web site, your reach extends beyond the more than 12,000 ACCP members to any pharmacist or student visiting the ACCP Web site to look for available positions. The Online Position Listings page is the second most-visited page on the ACCP Web site. Enhance your search further by posting a feature listing so that it appears at the top of any position search. For a more targeted search, employers can select specialists in one or more areas, or students, and have the position listing e-mailed to them directly.
- *ACCP Report* position listings provide another economical option for those seeking to fill positions now. ACCP's monthly e-newsletter, delivered directly to ACCP members, is a great venue for promoting available positions in academia, the pharmaceutical industry, and clinical practice.
- ACCP's monthly journal, *Pharmacotherapy,* also offers opportunities to promote open positions to the journal's audience of clinicians and scientists.
- The ACCP Residency and Fellowship Forum offers programs the opportunity to get a head start on next year's resident and fellow recruiting. The Residency and Fellowship Forum, scheduled on Monday, October 22, during the ACCP Annual Meeting, provides preceptors and program directors with an effective way to promote their programs and interview candidates who are seeking advanced-training positions. ACCP's online database of applicants will provide registered preceptors and program directors the ability to view resumes and contact potential applicants before the 2012 Annual Meeting. Programs interested in participating must have at least one current residency or fellowship position posted on ACCP's Online Position Listings and be registered for no less than a 1-day registration for Monday, October 22, of the 2012 ACCP Annual Meeting. Visit http://www.accp.com/meetings/am12/resfelForum.aspx for more information on this year's ACCP Residency and Fellowship Forum.

For more information on these and other recruitment opportunities available through ACCP, visit us online at www.accp.com/careers.

Report of the Nominations Committee

The 2012 Nominations Committee has recommended the following slate of candidates for the 2013 ACCP election. The election will occur in spring 2013, and successful candidates will assume office at the 2013 ACCP Annual Meeting in Albuquerque, New Mexico.

President-Elect:
- Rex Force, Pharm.D.; Pocatello, ID
- Judy Jacobi, Pharm.D.; Lebanon, IN

Regent:
- Richard Parrish, BSPharm, Ph.D.; Philadelphia, PA
- Leigh Ann Ross, Pharm.D.; Jackson, MS
- James Scott, Pharm.D.; Pomona, CA
- G. Christopher Wood, Pharm.D.; Memphis, TN

Research Institute Trustee:
- Mary Ensom, Pharm.D.; Vancouver, BC, Canada
- Reginald Frye, Pharm.D., Ph.D.; Gainesville, FL
- Paul Gubbins, Pharm.D.; Little Rock, AR
- Alan Zillich, Pharm.D.; Indianapolis, IN

Additional nominations may be made in writing to the Secretary of the College, Krystal Haase, ACCP, 13000 W. 87th Street Parkway, Lenexa, KS 66215. Nominations must state clearly the qualifications of the candidate, be signed by at least 74 *Full* Members (1% of eligible Full Members), and be submitted no later than September 21, 2012.

Respectfully submitted,
Joseph Guglielmo, Chair; Kimberly Tallian, Vice Chair; S. Diane Goodwin, Judy Cheng, Stuart Haines, J. Herbert Patterson, and Joseph Saseen

Register Now for "Last-Chance" BCPS/BCACP Review Webinars

accp online classroom

Do you plan to take the **Pharmacotherapy Specialty Certification Exam** or the **Ambulatory Care Pharmacy Specialty Certification Exam**, but find it difficult to start reviewing? Are you questioning whether you understand some key concepts? Could you use additional hours of continuing pharmacy education credit? **If so, the ACCP "Last-Chance Certification Review Webinars" are designed just for you!**

Avoid time-consuming and costly travel while reaping the benefits of brief concept overviews and vignette-based self-assessment questions and feedback led by nationally recognized content experts. The two interactive Web-based courses in Pharmacotherapy and Ambulatory Care Pharmacy will be delivered directly to your home, to your office, or to wherever you have broadband Internet access.

The respective specialty area will be covered during two live sessions, each lasting 3 hours. The Pharmacotherapy webinar will be offered on Tuesday and Wednesday evenings, September 4 and 5, 2012. The Ambulatory Care Pharmacy webinar will be offered on Thursday and Friday evenings, September 6 and 7, 2012.

Two different content areas will be covered each evening:

Tuesday, September 4 – Pharmacotherapy

- Biostatistics: 7:00–8:30 p.m. (EDT)
- Gastrointestinal Disorders: 8:30–10:00 p.m. (EDT)

Wednesday, September 5 – Pharmacotherapy

- Fluids and Electrolytes: 7:00–8:30 p.m. (EDT)
- Cardiology: 8:30–10:00 p.m. (EDT)

Thursday, September 6 – Ambulatory Care Pharmacy

- Biostatistics: 7:00–8:30 p.m. (EDT)
- Hypertension/Dyslipidemia: 8:30–10:00 p.m. (EDT)

Friday, September 7 – Ambulatory Care Pharmacy

- Psychiatric Disorders: 7:00–8:30 p.m. (EDT)
- Infectious Diseases: 8:30–10:00 p.m. (EDT)

Recordings of each session will be available beginning Tuesday, September 11. Therefore, if participants can't attend the programming presented on any individual evening, they will automatically have access to the recordings of each presentation. From a technical standpoint, it's easy. All you need is broadband Internet access, an Internet browser, Adobe Flash Player (already installed on more than 98% of devices currently connected to the Internet; otherwise, a free download), and speakers or headphones for audio.

Registration is only $149.95 per specialty area (either Pharmacotherapy or Ambulatory Care Pharmacy) for anyone who attended ACCP Updates in Therapeutics® 2012 or who purchased an ACCP Updates in Therapeutics® 2012 product. The cost is $179.95 per specialty area for all other ACCP members and $209.95 per specialty area for nonmembers. "Seats" are limited, so sign up early at www.accp.com/meetings/w-lc12/!

Washington Report

John McGlew
Associate Director of Government Affairs

Supreme Court Upholds Health Care Law

In the most closely watched and controversial case since the Bush v. Gore ruling that brought to an end the Florida recount in 2000, the Supreme Court upheld – by a margin of 5-4 – the individual mandate provision of the Affordable Care Act (ACA) that requires all Americans to purchase health insurance – or pay a fine.

There was initial confusion about the ruling because the court announced that it found the mandate unconstitutional under the Interstate Commerce Clause.

However, the ruling went on to clarify that the court considered the penalty for not purchasing health coverage a tax imposed by Congress. Under this interpretation, the court upheld the individual mandate and, in effect, much of the ACA.

"In the end, the Affordable Health Care Act survives largely unscathed," noted Justice Ruth Bader Ginsburg.[1]

Summary of the Court's Decision

The Individual Mandate

Central to the Obama administration's case was the assertion that Congress could require everyone to buy health insurance using its power under the Commerce Clause of the constitution. The administration argued

that failure to acquire insurance would ultimately shift the costs of health care for the uninsured to health care providers, insurance companies, and consumers of health insurance.

Five justices (Chief Justice Roberts and Justices Kennedy, Scalia, Thomas, and Alito) rejected this claim, arguing that the Commerce Clause assumes there is an activity to regulate. The decision to forgo health insurance coverage represents inactivity and so cannot be regulated.

However, a different group of five justices (Chief Justice Roberts and Justices Ginsburg, Breyer, Sotomayor, and Kagan) agreed that the penalty imposed by the mandate on those who chose not to buy health insurance coverage (in essence, the mandate's enforcement mechanism) constituted a tax and that Congress is empowered by the constitution to impose taxes.

Under this interpretation, individuals are at liberty to forgo health insurance coverage, but Congress is constitutionally entitled to impose taxes.

According to Chief Justice Roberts, "The federal government does not have the power to order people to buy health insurance. Section 5000A would therefore be unconstitutional if read as a command. The federal government does have the power to impose a tax on those without health insurance. Section 5000A is therefore constitutional because it can reasonably be read as a tax."[2]

ACA Severability

Because the court found the issue of the individual mandate constitutional, it did not have to consider the question of severability – whether all or any additional parts of the law had to be struck down if the mandate was rejected.

Medicaid Expansion

The court did strike one key provision of the ACA – the requirement that states expand their Medicaid programs to provide coverage for the uninsured. The law, as passed by Congress, would require states to significantly broaden Medicaid eligibility requirements to provide coverage for millions of Americans who are currently uninsured.

Although the federal government would initially pay for this expansion, the federal burden would drop to 90% beginning in 2020, with states required to fund the remainder. States that failed to comply with the costly Medicaid expansion would risk losing all federal Medicaid support.

It was this threat to existing Medicaid funding that the court found unconstitutional – judging that although the federal government can make funds available to states to allow Medicaid expansion to cover the uninsured, it can't require states to accept this funding.

Threatening to withhold all federal Medicaid funding, the court ruled, would in effect require states to participate in the expansion. Therefore, states that choose not to participate must be allowed to do so, without any threat to existing Medicaid funding.

Anti-Injunction Act

Finally, the court ruled that the Anti-Injunction Act – a statute that requires a tax to be levied before it can be challenged in court – did not apply in this instance.

Confusingly, the court ruled that although the penalty imposed on individuals who do not purchase health coverage is not technically a tax, Congress is entitled to impose the penalty under its broad authority to collect taxes.

President Obama's Reaction

Unsurprisingly, the reaction from the White House was one of jubilation. In comments made just after the Supreme Court delivered its verdict, the president reiterated many of his now well-worn themes on the law – highlighting the provisions that prohibit denial of coverage for preexisting conditions and those that allow young adults younger than 26 to stay on their parents' health care plans, as well as the promise to cover 30 million currently uninsured Americans.[3]

Governor Romney's Response

In contrast, Governor Mitt Romney, speaking on Capitol Hill, expressed his disappointment in the court's decision and vowed, if elected, to repeal and replace the ACA. The presumptive Republican nominee made it clear to opponents of the ACA that the November elections represent the next round in the fight over health care reform, with this call to arms: "This is a time of choice for the American people. Our mission is clear: If we want to get rid of Obamacare, we're going to have to replace President Obama."[4]

What Is Next for the ACA?

The controversy over health care reform, which so bitterly divided the nation, is unlikely to die out after the Supreme Court ruling.

With the individual mandate ruled constitutional through Congress' power to levy taxes, focus will shift to the November elections. If Republicans win control of the Senate and White House and retain the House of Representatives, their first priority will be to fulfill their pledge to repeal and replace Obamacare.

At the state level, the court's decision that states cannot be required (or coerced) to participate in Medicaid expansion could have an implications for the ACA's efforts to cover millions of American who are currently without insurance. However, with the federal government's willingness to pay 90% of the cost of expansion, this proposal might be too tempting for even the governors who are opposed to the law to turn down – the federal share of Medicaid spending is currently 67%.[5]

A CNN/ORC poll conducted immediately after the ruling found public opinion was largely unaffected by the court's decision, with 51% of Americans favoring a full repeal of the law and 47% wishing to keep all provisions in place.[6]

Both parties claim political advantage on the issue, and although the court upheld the law on constitutional grounds, the debate about whether it represents sound policy will continue.

Click here to read the Supreme Court's ruling in full.

1 *Washington Post article: Supreme Court Upholds Obama's Health-Care Law. Available at www.washingtonpost.com/politics/supreme-court-to-rule-thursday-on-health-care-law/2012/06/28/gJQAarRm8V_print.html. Accessed July 3, 2012.*

2 *National Federation of Independent Business v. Sebelius, Nos. 11-393, 11-398, and 11-400, 2012 BL 160004 (U.S. June 28, 2012). Available at www2.bloomberglaw.com/public/document/Natl_Federation_of_Independent_Business_v_Sebelius_No_11393_US_Ju. Accessed July 3, 2012.*

3 *White House press release – Remarks by the President on Supreme Court Ruling on the Affordable Care Act. Available at www.whitehouse.gov/the-press-office/2012/06/28/remarks-president-supreme-court-ruling-affordable-care-act. Accessed July 3, 2012.*

4 *Washington Post article: Romney's Response to Supreme Court Decision Thursday Upholding Obama Health Care Overhaul. Available at www.washingtonpost.com/national/romneys-response-to-supreme-court-decision-thursday-upholding-obama-health-care-overhaul/2012/06/28/gJQA1wIK9V_story.html. Accessed July 3, 2012.*

5 *Kaiser Family Foundation, State Health Factsheet: Federal and State Share of Medicaid Spending, FY2010. Available at www.statehealthfacts.org/comparemaptable.jsp?typ=2&ind=636&cat=4&sub=47. Accessed July 3, 2012.*

6 *CNN/ORC International Poll, June 28 – July 1, 2012. Available at www.realclearpolitics.com/docs/2012/CNN_healthcare_0702.pdf. Accessed July 3, 2012.*

Prepare for the 2012 BPS Pharmacotherapy or Ambulatory Exam with ACCP's Preparatory Review Courses

Are you planning to take the Board of Pharmacy Specialties (BPS) Pharmacotherapy or Ambulatory Care Pharmacy Specialty Certification Exam in October? Are you looking for a time-tested, proven preparatory course developed by the leader of board certification preparation products to guide your studying? **If so, take the home study version of the 2012 Ambulatory Care Pharmacy Preparatory Review and Recertification Course or the 2012 Pharmacotherapy Preparatory Review and Recertification Course to fully prepare! The home study versions contain the lectures from ACCP's internationally recognized live review course, held in Reno, Nevada, in April 2012. Instructional materials for both courses can be preordered today at www.accp.com/bookstore.**

By purchasing the home study version of either the Ambulatory Care Pharmacy Prep Course or the Pharmacotherapy Prep Course, you can avoid time-consuming, costly travel while reaping the benefits of nationally recognized content experts, whose fast-paced, yet comprehensive reviews of the full scope of the pharmacotherapy/ambulatory care specialty will help you reaffirm your areas of strength and identify potential weaknesses. Each home study course offers a detailed two-volume workbook covering more than 20 key therapeutic areas and providing more than 350 case-based questions and feedback for effective learning and self-assessment. This home study course will be delivered directly to your home, office, or anywhere you have either a computer or broadband Internet access. Instructional materials are available in one of the following formats: CD-ROM and printed course workbook package, Web-based online course package, or CD-ROM and online course workbook package.

To receive CPE credit for any of the home study packages, you must successfully complete and submit the Web-based posttest to ACCP by October 31, 2013. Orders for the Ambulatory Care Pharmacy Preparatory Review and Recertification Course or the Pharmacotherapy Preparatory Review and Recertification Course instructional materials may be placed online at www.accp.com/bookstore. Orders may also be placed by telephone at (913) 492-3311 or by fax at (913) 492-0088.

Learning objectives, faculty disclosures, target audience, program goals, technical requirements, and samples of each course are available at www.accp.com/bookstore.

Attention Students: Register Your Team for the 2012 Clinical Pharmacy Challenge by September 4

ACCP's national pharmacy student team competition returns in 2012. Now in its third year, the Clinical Pharmacy Challenge offers eligible teams the opportunity to compete in up to four online rounds, with the top eight teams advancing to the live quarterfinal competition at the 2012 ACCP Annual Meeting in Hollywood, Florida. Team registration is now available online. Please note all team registrations must be initiated by a current faculty member at the respective institution. Students interested in forming a team should contact their ACCP College of Pharmacy Faculty Liaison. All team registrations must be completed by the deadline of September 4, 2012. Click here to register.

Competition Overview

The ACCP Clinical Pharmacy Challenge is a team-based competition. Teams of three students will compete against teams from other schools and colleges of pharmacy in a "quiz bowl"–type format. Only one team per institution may enter the competition. Institutions with branch campuses, distance satellites, and/or several interested teams are encouraged to conduct a local competition. ACCP will provide a written examination that institutions may use as a basis for their local competition, if they so desire. This examination is available by e-mail request, which may be made by the ACCP Faculty Liaison or registering faculty member. Please address your e-mail request to Michelle Kucera, Pharm.D., BCPS, at mkucera@accp.com.

Preliminary rounds of the national competition will be conducted virtually in September. The quarterfinal, semifinal, and final rounds will be held live at the ACCP Annual Meeting in Hollywood, Florida, October 20–22, 2012. Competition Schedule.

Each round will consist of questions offered in the three distinct segments indicated below. Item content used in each segment has been developed and reviewed by an expert panel of clinical pharmacy practitioners and educators.

- Trivia/Lightning
- Clinical Case
- Jeopardy-style

Each team advancing to the quarterfinal round held at the ACCP Annual Meeting will receive three complimentary student full meeting registrations. Each team member will receive an ACCP gift certificate for $125 and a certificate of recognition. In addition, semifinal teams not advancing to the final round will receive a semifinal team plaque for display at their institution. The second-place team will receive a $750 cash award ($250 to each member) and a commemorative team plaque. The winning team will receive a $1500 cash award ($500 to each member), and each team member will receive a commemorative plaque. A team trophy will be awarded to the winning institution.

Students are not required to be members of ACCP to participate. Team registration may be submitted online and must be initiated by a current faculty member at the respective institution. Students interested in forming a team should contact their ACCP Faculty Liason. If no ACCP Faculty Liaison has been identified, any faculty member from the institution may initiate the registration process. The registering faculty member must confirm the eligibility of all team members and/ or alternates online before a team will be permitted to compete in the Clinical Pharmacy Challenge. **The deadline to complete team registration and confirm eligibility is September 4, 2012.**

Click here for more information, or contact Michelle Kucera, Pharm.D., BCPS, at mkucera@accp.com.

Attention Students, Residents, and Fellows: Apply Online Now for 2012 ACCP Annual Meeting Travel Awards

Have you thought about attending an ACCP meeting, but have limited financial resources available to cover your travel and registration costs? ACCP and its members want to help!

ACCP Student Travel Awards and Resident/Fellow Travel Awards enable students and postgraduate trainees to attend ACCP meetings by awarding travel stipends and/or complimentary meeting registrations. Apply online now for an award to attend the ACCP Annual Meeting in Hollywood, Florida, October 21–24, 2012.

How to Apply

Students: Student members of ACCP who are full-time pharmacy students pursuing their first professional pharmacy degree are invited to apply for an award. Applicants are asked to submit a completed application, which includes a curriculum vitae or resume, two letters of reference, and an essay of no more than 500 words detailing the applicant's objectives for attending

an ACCP meeting. All application materials should be submitted online at http://www.accp.com/stunet/award.aspx. *The application deadline is September 7, 2012.*

Residents/Fellows: To qualify, applicants must be current resident or fellow members of ACCP who are enrolled in a residency or fellowship program at the time of the meeting. Applicants must submit a curriculum vitae, an essay of no more than 250 words detailing their objectives for attending an ACCP meeting, and a personal reference from the residency or fellowship program director or his or her designee. All application materials should be submitted online at www.accp.com/membership/resfelAward.aspx. *The application deadline is August 24, 2012.*

For more information on ACCP travel awards, contact Jon Poynter, ACCP Senior Membership Project Manager, at jpoynter@accp.com or (913) 492-3311, ext. 21.

ACCP's Popular Online Curriculum Vitae Review Program Returns

As the clinical pharmacy profession continues to experience an increase in demand and competition for residency positions and first-rate jobs, it is vital that students and postgraduate trainees have a well-written CV. An effective CV provides a positive image and can help distinguish an individual from the rest of the crowd. As questions arise in preparing and completing a CV, wouldn't it be helpful to have a seasoned professional review it?

Now through May 31, 2013, student, resident, and fellow members may submit their CVs online as a Microsoft Word document and have them randomly assigned to a volunteer ACCP member reviewer. The ACCP reviewer will provide his or her comments and suggested edits using the track changes feature in Microsoft Word. Participants will receive an e-mail within 2 weeks containing feedback from the reviewer.

When preparing a CV for review, be sure to take advantage of ACCP's other Web-based resources. Learn or review the basics of CV formatting, view sample CVs, and access valuable "curriculum vitae pearls," which provide practical insights in developing a CV. These services and other resources are accessible from the ACCP Web site at http://www.accp.com/stunet/cv.aspx. For questions about the ACCP CV Review Service, contact Michelle Kucera, Pharm.D., BCPS, at mkucera@accp.com.

ACCP PBRN: Continued Growth in Numbers

We would like to thank everyone who took time to register with the ACCP PBRN. In addition, we would like to provide an update of our progress.

To date (as of July 31, 2012), the PBRN has 777 individual members. ACCP PBRN participants provide clinical pharmacy services an average of 6 half-days/week. This represents a total of 2934 half-days/week on the basis of individual pharmacist responses to our registry survey. For the 489 pharmacists who provide direct patient care, the median number of patients seen by our PBRN members each week is 42. This equates to 20,538 patient encounters by our PBRN clinical pharmacist members in 1 week and more than 1 million encounters annually.

Around 35% of ACCP PBRN members use scope of practice or collaborative care agreements. All the PRNs are represented. As such, the ACCP PBRN membership reflects a true cross-section of the ACCP membership, as shown in the table that follows.

ACCP PBRN Membership by PRN

Count	PRN Code	PRN Name
80	AMED	Adult Medicine
168	AMBU	Ambulatory Care
103	CARD	Cardiology
19	CNSY	Central Nervous System
23	CADM	Clinical Administration
98	CRIT	Critical Care
6	DINF	Drug Information
59	EDTR	Education and Training
17	EMED	Emergency Medicine
30	ENDO	Endocrine and Metabolism
26	GERI	Geriatrics
16	GILN	GI/Liver/Nutrition
14	OCEC	Health Outcomes
51	HMON	Hematology/Oncology
39	IMTR	Immunology/Transplantation
86	INFD	Infectious Diseases
25	NEPH	Nephrology
29	PAIN	Pain and Palliative Care
41	PEDI	Pediatrics
4	INDU	Pharmaceutical Industry
17	PK/PD/PG	Pharmacokinetics/Pharmacodynamics/Pharmacogenomics
18	WOMN	Women's Health

Four hundred thirty-nine sites are registered in 50 states and 15 countries. About 47% of our ACCP PBRN members practice in an inpatient setting, 32% practice in an outpatient setting, and the remaining 20% practice in a managed care, community health center, long-term care, community pharmacy, government, or other setting. Eighty-five percent of practice sites are located in urban areas with populations of more than 500,000 people. Almost two-thirds of our members use electronic medical records, and virtually all have Internet and e-mail capabilities (86%).

The ACCP PBRN encourages interested investigators to contact the PBRN with their project ideas. In addition, the ACCP PBRN is available to support the practice-based research efforts of its membership. Contact us today with your comments and suggestions at pbrn@accp.com.

ACCP PBRN Community Advisory Panel Members Available for Local Educational Events

Do you have an upcoming local event, faculty conference, or practitioner meeting in which a cohort of ACCP members will be present? Do you want a speaker with experience in a practice-based research network to present to your group? The ACCP PBRN may be able to help.

Whether you are interested in learning more about the mission and function of the ACCP PBRN, needing insight regarding PBRN research, or wanting to establish collaborative research efforts with both internal and external stakeholders, the Community Advisory Panel (CAP) members of the ACCP PBRN may be able to provide an educational session at your site.

The CAP is a standing committee of the ACCP PBRN with the mission of representing the breadth and depth of ACCP PBRN members. The experience of CAP members and the type of their clinical practice sites and specialties vary, mirroring the overall population of the ACCP PBRN membership. CAP members practice in ambulatory care, cardiology, family medicine, health outcomes, pediatrics, and pharmacy administration at sites across the United States. The 2012 CAP members are Lori Dickerson, Chair; Rex Force, Vice Chair; David Hoff; Orly Vardeny; Nathan Painter; Alan Zillich; Kari Olson; Varsha Bhatt-Mehta; Richard Parrish II; and Kelly Rudd. In addition to providing educational assistance, the CAP is used as a mechanism for readily available feedback regarding the feasibility and practicality of proposed research projects. CAP members are called on to review research proposals, apply beta testing to data collection methods, and provide input on IRB applications.

Although the ACCP PBRN would like to accommodate all requests for local meetings, its resources and time are limited. Interested parties are asked to contact us at pbrn@accp.com to determine whether we can provide local support. We look forward to hearing from you.

Research Institute to Sponsor 2013 FIT Applicant with PBRN Proposal

Do you have the next ACCP PBRN project idea but could use some help in improving your proposal? Could you use the assistance of members across the United States to answer your research question in a more robust manner? Submit your proposal to the 2013 FIT Program. The Board of Trustees is pleased to offer full registration support for one FIT applicant with an ACCP PBRN project idea. The award will be given on a competitive basis, with the goal of increasing the number and competitiveness of projects submitted to the ACCP PBRN.

The ACCP PBRN can produce research findings that are immediately relevant to the clinician and that, in theory, are more easily translated into practice. Practice-based research networks can link relevant clinical questions with rigorous research methods in real-life settings and produce scientific information that is not only externally valid, but also, in essence, easily assimilated into everyday practice.

The FIT Program is open to pharmacists with research proposals in all areas of interest. Read what previous attendees have to say about the FIT Program.

Christopher Frei, Pharm.D., M.S., BCPS
College of Pharmacy, The
University of Texas at Austin
FIT Class of 2008

The FIT Program was an integral part of my research and career development. The knowledgeable mentors helped me write my first federal grant application, which was subsequently funded by NIH. I still

keep in touch with one of my FIT mentors to this day. I highly recommend this experience to all junior investigators who want to improve their grant-writing skills and better understand the NIH culture.

In 2010, Dr. Frei received a 2-year grant funded for $227,257 for a project titled "Genetics, Resistance, and Treatment in a South Texas Practice-Based Research Network." His award is a Mentored Research and Career Development Program (KL2) in Clinical and Translational Sciences grant, funded by NIH's National Center for Research Resources. That same year, he also received a $153,555 industry grant from Pfizer Pharmaceuticals. At the beginning of 2012, he received a foundation grant from Bristol-Myers Squibb for $172,122.

David Feola, Pharm.D., Ph.D.
University of Kentucky College of Pharmacy
FIT Class of 2008

The ACCP Focused Investigator Training Program had a huge impact on my ability to write grant proposals. The proposal that was funded by the NIH was developed through the FIT Program—the information I learned there, along with the interaction and assistance from my FIT mentors, was invaluable. The funding of this award is a testament to how important the FIT Program is for junior faculty in academic pharmacy.

In 2012, Dr. Feola received a 5-year grant funded for $1.8 million titled "Alternative Macrophage Activation in Acute Pseudomonas Pneumonia." His grant is an investigator-initiated research project (R01), funded by NIH's National Institute of Allergy and Infectious Diseases.

The 2013 FIT Program will be held July 27–31, 2013, at the University of Georgia College of Pharmacy. The new *revised* application will be available soon. For more information, contact the ACCP Research Institute at (913) 492-3311.

ACCP Provides Comment to URAC, APhA on Proposed Accreditation Standards for Community Pharmacies

Two different organizations recently published draft standards for the accreditation of community pharmacies. The organizations are URAC (www.urac.org), which has accreditation programs in place for a variety of entities, including patient-centered health care homes and mail-service pharmacy programs; and the Center for Pharmacy Practice Accreditation, a newly established joint venture of the American Pharmacists Association and the National Association of Boards of Pharmacy. Comment periods for both sets of draft standards close in mid-August.

Although the proposed standards deal primarily with facility quality review and operational aspects of community pharmacy practice, some standards touch on issues regarding the quality of patient care services offered within the community pharmacy setting. ACCP's comments suggested the need for a specific standard on the credentialing of pharmacists within these practices that would ensure the alignment of pharmacists' qualifications with the scope of services being offered or promoted within that practice setting. ACCP's comments were submitted to both organizations and are presented below in abridged form:

ACCP urges the inclusion of a standard … that ensures that the community pharmacy practice being evaluated has a process/procedure in place, and consistently uses that process/procedure, to document the qualifications, training, voluntary post-licensure certifications, and/or other skill sets that align with and ensure the quality of the scope of services proposed to be offered by the practice. For example, if a community pharmacy provides, advertises, [and] promotes … patient care services in areas such as outpatient oncology care, nutrition support, and immunization practices, documentation of the qualifications and training of one or more pharmacists in that practice exists to safely and appropriately provide those specialized services.

ACCP further suggests that consideration be given to establishing "tiers" of accreditation that may be relevant to the comment above. Examples in other accreditation spheres would include CMS's tiered recognition of patient-centered medical home (PCMH) practices or the "graduated" accreditation status of newly established schools of pharmacy as they progress through various points of degree program implementation and delivery. This would allow an incorporation of both minimal and "aspirational" standards as community pharmacies evolve into practices more fully focused on direct patient care services.

Format Changes and New Release Schedule Announced for Next Pharmacotherapy Self-Assessment Program (PSAP)

Continuing its long history of providing recertification products for the Board Certified Pharmacotherapy Specialist, ACCP will launch the new edition of the Pharmacotherapy Self-Assessment Program (PSAP) on January 15, 2013.

Now entering its third decade, PSAP remains committed to its mission of providing the BCPS with the latest evidence-based updates in focused therapeutic areas. This premier home study program provides information in an easy-to-access format that enables the pharmacotherapy specialist to immediately integrate it into clinical practice.

Subscribers to the eighth edition will notice several new features designed to enhance learning and promote application of updates to patient care. These changes include:

- Condensed releases that offer complete coverage of the BCPS topic areas in only two books per year (January and July).
- In-text references to the most recent primary literature (past 3–5 years).
- Hyperlinks to guidelines, online tools, and other pharmacy resources.
- New graphic features that translate evidence-based updates directly to patient care, including Pivotal Study That May Change Practice, Patient Care Scenario, and Practice Points.
- Extension of the BCPS testing period from 3 months to 4 months.

The new PSAP edition will release six books from 2013 to 2015. The PSAP series will provide the BCPS with more than the required 120 continuing pharmacy education credits needed to recertify.

Cardiology/Endocrinology will be the first book in the new series. Serving as faculty panel chair for 2013 Book 1 is Robert L. Page II, Pharm.D., MSPH, FCCP, BCPS. *Special Populations* will be the second book in the series. Serving as faculty panel chair is J. Mark Ruscin, Pharm.D., BCPS. Leading the new edition as PSAP series editors are John E. Murphy, Pharm.D., FCCP, FASHP; and Mary Wun-Len Lee, Pharm.D., FCCP, BCPS. Book release and test deadlines for the new series are as follows:

	Release Date	BCPS Test Deadline	ACPE Test Deadline
2013 Book 1 Cardiology/Endocrinology	January 15, 2013	May 15, 2013	January 31, 2016
2013 Book 2 Special Populations	July 15, 2013	November 15, 2013	July 31, 2016
2014 Book 1 Critical and Urgent Care	January 15, 2014	May 15, 2014	January 31, 2017
2014 Book 2 Chronic Illnesses	July 15, 2014	November 17, 2014	July 31, 2017
2015 Book 1 Infectious Diseases	January 15, 2015	May 15, 2015	January 31, 2018
2015 Book 2 CNS and Pharmacy Practice	July 15, 2015	November 16, 2015	July 31, 2018

Single and series sales of PSAP will start in October 2012. For more information and series updates as they become available, visit www.accp.com/bookstore/psap8.aspx.

Pharmacotherapy Pearls

Pharmacotherapy's Impact Factor Report

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

The Institute for Scientific Information (ISI) impact factor is a measure used by researchers, authors, and libraries to judge the overall "quality" of a journal. Journals with higher impact factors are held to be more prestigious and of higher impact than those with lower impact factors. Indeed, tenure and promotion committees often assess not only a candidate's number of publications but also the impact factor of the journals in which the candidate has published.

Pharmacotherapy's most recent 1-year impact factor has gratifyingly increased (from 2.631 to 2.900). The journal's 5-year impact factor has also increased (from 2.260 to 2.423). These are the highest impact factors among the pharmacy journals. We have created the following report so that you can see the relevant data for each pharmacy journal.

Journal	Total Cites	Articles	5-Year Impact Factor	Rank Impact Factor	(x/260)
Pharmacotherapy	4396	139	2.900	2.423	85
AJHP	3436	112	1.962	1.844	144
Annals of Pharmacotherapy	5886	158	2.126	2.199	132
JAPhA	1492	64	1.476	1.538	185
JMCP	961	45	2.250	2.084	125
AJPE	1301	80	1.193	1.421	196

MEDIAN IMPACT FACTOR FOR ALL PHARMACY & PHARMACOLOGY (260 JOURNALS): 2.153

ISI Impact Factor

The ISI impact factor reported each year reflects data from the previous 2 years. The 2011 impact factor is calculated as follows:

$$\frac{\text{number of cites in 2011 to articles published in 2009 and 2010}}{\text{number of articles published in 2009 and 2010}}$$

Ranking in the pharmacy and pharmacology journal category is by *x*/*N*, where *x* is the rank and *N* is the number of journals.

Comparative data with other journals in this category are also shown below:

Year	PPI	DICP	AJHP
2005			
IF	1.920	1.837	1.437
x/192	93	98	120
2006			
IF	1.900	2.259	1.935
x/199	103	85	102
2007			
IF	2.012	1.985	1.708
5-YR IF	2.026	1.918	1.621
x/205	112	113	126
2008			
IF	2.527	2.305	1.763
5-YR IF	2.347	2.153	1.744
x/216	91	106	135
2009			
IF	2.726	2.453	2.097
5-YR IF	2.255	2.190	1.961
x/236	90	111	132
2010			
IF	2.631	2.166	2.219
5-YR IF	2.260	2.163	1.967
x/249	101	135	130
2011			
IF	2.900	2.126	1.962
5-YR IF	2.423	2.199	1.844
x/260	85	132	144

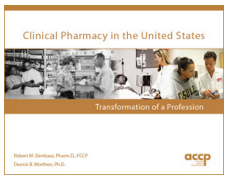
AJHP = *American Journal of Health-System Pharmacy*; DICP = *Annals of Pharmacotherapy*; IF = impact factor; PPI = *Pharmacotherapy*.

Five-year impact factors have only been compiled by ISI JCR since 2007.

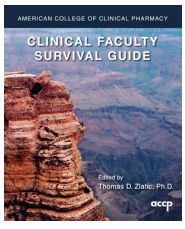
Back-to-School Special at the ACCP Bookstore

As the new academic year approaches, it is time for those back-to-school specials. The ACCP Bookstore is ready with a special offer on select ACCP publications. Whether you are a new or experienced faculty member or a student or resident, the ACCP Bookstore can enhance your professional resource collection.

When you visit the ACCP Bookstore at www.accp.com/bookstore, place an order for any of the popular titles featured below, enter the promotion code **BTS15**, and automatically receive **15% off** member or nonmember pricing. Available titles include:



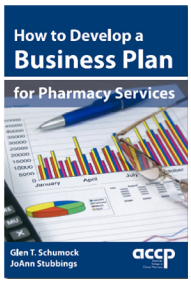
Clinical Pharmacy in the United States: Transformation of a Profession is a comprehensive account of the evolution of clinical pharmacy and is a must-read for anyone who cares about the profession of pharmacy. This book's unique design offers an important context beyond pharmacy by providing an overview of U.S. culture, politics, economics, technology, health care, and other events – chronicled alongside the major clinical pharmacy events of the past several decades. Throughout the book are reflective essays written by the leaders of our profession.



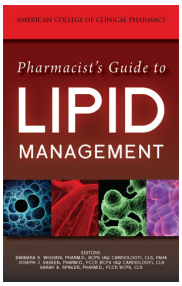
Clinical Faculty Survival Guide provides clinical faculty practical information, advice, and encouragement for succeeding in the roles of practitioner, teacher, researcher, and scholar. You will find the content advanta-

geous whether you are a new or seasoned faculty member or a resident, fellow, or graduate student. The advice provided by the ***Clinical Faculty Survival Guide*** will make this a valuable addition to your professional library.

If you are a resident, are planning to be a resident, or are involved in resident training, the ***Resident Survival Guide*** is your best resource for negotiating your entire residency experience. When you choose to become a pharmacy resident, a world of opportunities and challenges is opened up to you. This guide has been developed to assist you in meeting those challenges and taking advantage of those opportunities.

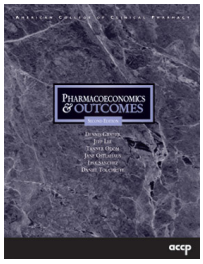


How to Develop a Business Plan for Pharmacy Services provides an important resource for planning, developing, launching, and evaluating business services for the pharmacy field. Assistance for pharmacy clinicians, managers, and leaders in implementing new services and enhancing existing services is presented by a systematic approach. The advice and analysis will be invaluable in your real-world practice setting.



Pharmacist's Guide to Lipid Management provides pharmacists the information they need to fight against the No. 1 killer of men and women—coronary artery disease. The information you need to know about risk factors, risk-stratifying patients, and optimizing treatment while minimizing adverse effects is all in this easy-to-use guide for managing patients with lipid disorders.

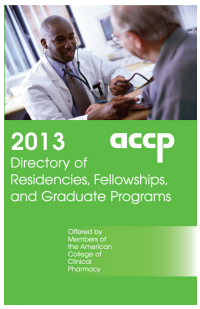
For many years, the ***Pediatric Medication Education Text*** has been the go-to publication for pediatric practitioners needing to access medication information to provide pediatric caregivers. Information on more than 389 of the most commonly prescribed pediatric medications is available in both the English and Spanish language handouts. If you are involved in treating pediatric patients in hospital and ambulatory care settings, you will want access to the ***Pediatric Medication Education Text*** (available in CD-ROM or online formats).



Pharmacoeconomics & Outcomes: Applications for Patient Care introduces the technology and basic components of health care economics, outcomes research, and pharmacoeconomics. Intended to equip pharmacists and pharmacy students with the knowledge needed to evaluate economic and patient-based outcomes, this book provides strategies for designing research questions, a process to conduct a pharmacoeconomics evaluation, and sources of data for an economic outcomes analysis. Also available is the companion book containing 12 case studies to enhance your learning experience.

This offer will be valid until midnight, Monday, September 3, 2012. Take advantage of this special opportunity to purchase these favorite titles. Order online at www.accp.com/bookstore; by telephone at (913) 492-3311; or by fax at (913) 492-0088. Remember to add promotion code **BTS15** to your order to receive special pricing.

Call for New and Updated Training Program Directory Listings: Deadline Is August 24



The *ACCP Directory of Residencies, Fellowships, and Graduate Programs* is available both on the Web and in print. The 2013 print directory will be distributed this December to prospective residency, fellowship, and program candidates and to each U.S. school and college of pharmacy. All ACCP members who serve as principal preceptors of residencies, fellowships, or clinical scientist graduate degree programs (M.S., Ph.D.) are encouraged to list or update their programs in the directory no later than August 24, 2012.

Responses received by August 24 will be listed in the 2013 print directory. The directory will be available in November 2012 and distributed to students, residents, and practitioners at the 2012 ASHP Midyear Clinical Meeting and the 2013 APhA Annual Meeting. In addition, the directory will be sent at no charge to any ACCP member who requests a copy (see future editions of the *ACCP Report* and the ACCP Web site for information on how to request a copy of the 2013 directory). The College provides this as a complimentary service to ACCP members. All listings must be

updated, however; listings will automatically expire if they are not updated annually, even if a program is already listed in the directory.

The College has notified all ACCP members by e-mail and asked them to update their listings by verifying accuracy and making any needed changes. This ensures that all listings are correct and up-to-date for prospective applicants, who rely on this information. Directory listings that are not updated and verified by the deadline above, however, will be automatically removed from the directory. It is easy to list or update a program. Last year's listings already appear on the directory Web site. To add, edit, or delete a listing, go to http://www.accp.com/resandfel. If an ACCP member already has a program listed in the current directory, he or she can just open it, make any changes or additions, and resubmit it. If the member has forgotten his or her password, it can be accessed through ACCP's password reminder system at http://www.accp.com/signin/forgotPassword.aspx.

Remember, listings must be added, updated, or deleted by August 24, 2012. If any member experiences technical difficulties or has questions regarding directory updates, he or she should contact Brent Paloutzian at bpaloutzian@accp.com.

2013 Committee and Task Force Progress Report

ACCP thanks the more than 800 ACCP members who expressed interest in devoting time to committees, task forces, and other volunteer activities during the upcoming year. All members were asked to indicate the specific ACCP activities in which they were interested by responding to ACCP's annual survey for volunteers, conducted from June 29 to July 20. President-Elect Curtis Haas is expected to complete the initial committee roster assignments soon, and committee/task force e-mail invitations will be sent to members by September 7. Because some members may find themselves unable to serve, it is expected that additional invitations will be distributed later in September. ACCP will provide a final update on 2013 committees and task forces in next month's newsletter.

New Members

Mariam Abboud
Osama Abu Tabar
Mobolaji Adeola
Mariam Ahmed
Diala Ajam
Mutasem Almistarihi
Kristen Alspaugh
Stephanie Altepeter
Megan Andrews
Judy Arnold
Ali Atabaki
Neli Attas
Christy Austin
Jenna Bacchus
Sebastian Biglione
Anthony Blackford
Michelle Boguslaski
Kara Bonaceto
Scott Bragg
Derek Bremmer
Beth Brubaker
Dustin Bryan
Nancy Burge
Luba Burman
Robert Bush
Blake Carley
Jennifer Carpenter
Bonnie Chan
Arlene Cheng
Ruth Choi
Andrew Choma
Nicholas Chung
Jessica Conklin
Kelly Considine
Lindsey Cross
Stacy Crow
Sarah Cruz
Chelsea Davis
David Davis
Judith Davis
Anne Deitrich
Emine Ceren Demircioglu
Jodi DeMonte
Caroline Der-Nigoghossian
Gabriella Douglass
Colleen Drasga
Shrina Duggal
Eliza Dy
Gregory Edmiston
Christopher Elder
Mohamed Elhaddad
Jerry Fairbanks
Megan Fleischman
Dyan Fleming
Thad Franz
Abby Frye
Diana Gabriel
Adinoyi Garba
Rhianna Godios
Siao Reow Gooi
Nathan Gorney
Jaci Grafenberg
Caroline Griggs
Seung Ha
Samantha Hacker
Daniel Hassell
Emily Hays
Darren Hein
Joe Hessell
Lindsay Hoffman
Martina Holder
Emily Holm
Amira Hosni-Ahmed
Jin Huh
Lauren Hutton
Bethany Ibach
Lauren Igneri
Jeong Jolee
Jennifer Jones
Laura Jones
Mathew Jones
Angelica Judilla
Farah Kablaoui
Barbara Kalist
Alan Kamida
Wonku Kang
Eric Kanouse
Alyssa Keating
Megan Kehrli
Catherine Kim
Eunyoung Kim
Miae Kim
Thomas Kleyn
Jason Kong

Kimberly Kosloski
Eric Kowalek
Ching Chi Kwok
Jonathan Lacro
Anh Lam
Eric Lambart
Sarah Le
Robin Leaders
Alison Leavitt
Amy Lee
Hannah Lee
Helen Lee
Enrico Ligniti
Anne Lu
Victor Ly
C. Masuda
Lindsay McCann
Kristin McClung
Kasidy McKay
Jessica McKeon
Helen McKnight
Richa Mehta
Sanaa Mekdad
Mia Monson
William Moore
Miranda Moriarity
Megan Mormann
Misbah Moten
Elizabeth Murias
Robert Newsome
Thanh-Hang Nguyen
Trai Nguyen Zoldan
Arezo Noormohammadi
Christopher Norris
Chinyelu Onwumbiko
Patricia Orajaka
Jigna Patel
Kelli Paul
Sarah Payne
Tushia Perry
Janise Phillips
Quang Phung
Jennifer Polzin
Muhammad Qudoos
Erum Rahman
Lance Ray
Samantha Reiss
Hong Rhee
Nathaniel Rhodes
Leonor Rojas
Mark Rosenberg
Tracy Rosenblum
Edward Saito
Miyuku Sakai
Peter Sardarbekians
Kathleen Sargent
Lindsay Schaack
Ali Shah
Prachi Shah
Sonia Shah
Shafeeque Shaikh
Kathrine Sheets
Joseph Shoyoye
Donna Shuler
Andrea Sikora
Leann Silhan
Elizabeth Sinclair
Maria Sisneros
Jordan Smith
Megan Smith
Sarah Smith
Somer Smith
Selvin Soby
Yong-Bum Song
Lindsay Sorge
Jennifer Sposito
Megan Stapleton
Chandra Steenhoek
Erin Steffensen
Tera Stock
Paul Stranges
Kristina Sucic
Emily Sullivan
Colleen Summe
Andrea Susi
Siddharth Swamy
Keith Teelucksingh
Lacy Ternes
Martin Tuan Tran
Van Tran
Christine Trezza
Tanya Uritsky
Eric Urnoski
Tyler Van Schyndel
Jineane Venci
Claire Walter
Benjamin Wang
Wei Wang
Lynn Weber
Wenjing Wei
Jason Williamson
Matthrew Wolf
Lauren Woller
Relin Yang
Ayberk Yenilmez
Erum Zahid

The following individuals recently advanced from Associate to Full Member:

Sara Alvarez
Paige Austin
Hannah Bursiek
Jessica Casey
Jonathan Edwards
Lauren Haak
Amie Hatch
Johannah Heaphy
Ryan Hinman
Augustus Hough
Aimee Kurzawski
Janet Meredith
Robert Miller
Keliana Omara
Mona Patel
Lauren Peyton
Robin Pucci
Morgan Sayler
Geoffrey Twigg
Kelly Valla
Sheri VanOsdol
Kuo Yang
Tracy Zembles

New Member Recruiters

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

Douglas Anderson
Christina Askew
Kristen Bova Campbell
Mason Bucklin
Christy Burrows-Grandstaff
Corinne Chahine
John Cleary
Rebeccah Collins
Jean Dib
Erica Dobson
Jennifer Donovan
Cathy Ficzere
Philip Gregory
Sara Griesbach
Michael Hardy
Terreia Jones
Chad Kawakami
Susan Kidd
Brandi LaFrance
Kristy Lucas
William Musick
Tien Ng
Amy Barton Pai
Jighna Patel
Kyle Peters
Rebecca Pettit
Anusha Raju
Tom Richardson
Nancy Ross
Harminder Sikand
Jeffrey Tingen
David Zgarrick