



# Rxtra! Rxtra!

## ACCP Ambulatory Care PRN Newsletter

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## Patient Centered Medical Home

### PRN Focus

The Patient Centered Medical Home (PCMH) is an approach to healthcare that involves a multidisciplinary team to provide complete patient care. The term "medical home" was created by the America Academy of Pediatrics decades ago and in 2004 the American Academy of Family Physicians began to embrace the model.<sup>1</sup> PCMH has become an increasingly attractive approach to healthcare as the US continues to have rising healthcare costs while the quality of care is decreasing. In the most recent statistics published by the World Health Organization the United States ranked 72 out of 191 countries in overall health system performance, indicating a need for change.<sup>2</sup>

The Patient Centered Medical Home is based on patient driven care. The patient's medical provider works with a healthcare team consisting of mid-level providers, nurses, social workers, dietitians, pharmacists, physical therapists, occupational therapists, family and community. The patient will receive referrals to specialty care as necessary and initiated through primary care. This team of health care professionals is able to extend the time for patient needs to be addressed versus the older model of care that consisted of a short office visit with the physician. The patient receives care for chronic disease states in a multidisciplinary approach improving outcomes and in turn lowering costs. Cost savings

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were analyzed in Bridges to Excellence which estimated that maintaining and A1c of 7% in diabetic patients saves \$279 a year, LDL below 100 saves \$369 per year and keeping blood pressure below 130/80 mmHg reduces health care costs by \$494 per year. This results in a saving of \$1,059 per patient per year if all of these important laboratory goals are met.<sup>1</sup> Thus the PCMH may provide an improved quality of care through a team approach which is beneficial in patient outcomes and reducing costs.

The National Committee for Quality Assurance (NCQA) is an organization that has established criteria for becoming an accredited PCMH. There are 9 standards and 10 must pass elements that must be met for the PCMH to receive one of three levels of recognition. They measure specifically a patient's access and communication with the PCMH, patient tracking and registry functions, care management, patient self-management support, electronic prescribing, test tracking, referral tracking, performance reporting and improvement and advanced electronic communications. If the PCMH is awarded recognition by NCQA physicians are nationally recognized and the practice is qualified to receive additional payment and financial support from the government and other payers.<sup>3</sup>

Nutting and colleagues conducted a National Demonstration Project on the PCMH model to evaluate the effect the model has on both

the patient and practice outcomes. In the NDP clinics were faced with many challenges. Technology is an important component of the PCMH. However, there are few computer programs available for purchase that are able to provide all of the desired services to the clinic. As a result, many PCMHs struggle to implement this technology into practice in a cost effective manner.

Not only is technology transformed, but the staff must also be transformed and taught to focus on the patient's health goals as well as the patient's current health status. Physicians are also instructed to take stronger roles as leaders and teachers. This often requires education and support of the physicians to aid the health care team in functioning as a cohesive unit rather than having a top-down or authoritative infrastructure. Nutting and colleagues suggest incorporating time into schedules as the shift to the PCMH is made for reflection and planning time among the group. Time for reflection and planning is also important because changes to the practice often cause fatigue and stress which may decrease motivation, productivity, increase turnover and cause a financial stress. However, each practice will be different and should modify its transition to the PCMH to fit the needs of the staff and patients.<sup>4</sup>

Pharmacists can take an active role on the health care team in the PCMH. Pharmacists have proven their interventions to be beneficial in increasing positive health outcomes and decreasing

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## PRN Chair's Corner

**Nicole Culhane, PharmD, BCPS, FCCP**

I am truly humbled to serve you as Chair of the PRN. As I reflect back on the last six months as Chair and over the past three years as an officer, one word comes to mind - 'opportunity'. One definition for the word opportunity is 'a good chance for advancement or progress'. I think our PRN exemplifies this definition in so many ways. Our members are involved in developing and sustaining model clinical practices, conducting high level, high quality research, and sharing their practice and research to shape the future of pharmacy. Through my involvement in the PRN, I have been afforded many opportunities, namely to work with and get to know so many talented and innovative individuals. Despite our large size, our PRN creates a culture of inclusion that not only encourages members to get involved but makes it easy to be and stay involved. I would like to discuss some of the ways in which I plan to increase opportunities for our members.



The PRN has moved to a committee structure similar to the College structure. Our committees now have a Chair and Vice-Chair. The primary purpose of implementing this change was to create more opportunity for members to get involved and to assume more of a leadership role within the committee. Serving as Vice-Chair for a year allows an individual to share the responsibility with the Chair and to gain experience working on the committee before taking over as Chair. Our hope is that this model will encourage increased involvement in committees and future officer positions.

The PRN shares the vision of the College which is to increase student and resident involvement. Our PRN has already been sponsoring a student to travel to an ACCP meeting and this year we expanded our sponsorship to include a resident travel award. Our resident and student committee has also been very active in trying to engage students and residents in networking opportunities at our PRN meetings. At the Spring meeting we had more than 20 residents and students participating in a group activity and discussion following the meeting.

The PRN has a long standing mission of promoting research and scholarship among its members. With the changes occurring at the College level with the Research Institute and the formation of the Practice Based Research Network, I charged the Research and Scholarship Committee along with the Budget and Finance Committee to develop an application process and monetary designation to sponsor a member of the PRN to attend the Focused Investigator Training (FIT) program.

Advocacy efforts remain at the top of the PRN's priority list. Whether on Capitol Hill or in our own backyards, it is important for each one of us to embrace every opportunity to promote our profession. This year I charged the advocacy committee with developing creative ways to educate our membership about advocacy and professional affairs. There are so many opportunities for pharmacists with the passing of the health care reform bill and now is the time we have to work on securing our seat at the table.

My heartfelt thanks goes to all of the PRN officers, committee chairs/vice-chairs and committee members for all of their hard work and dedication to the PRN. These individuals do all of the 'behind the scenes' work that is essential to the progress and advancement of the PRN. This past Fall, we had over 100 members volunteer for committee service. Serving on a committee is a wonderful way to increase your involvement within the PRN. I encourage all of you to become more involved in the PRN in whatever capacity you feel will enable you to grow. Seize the opportunity!

Thank you for giving me the opportunity to serve the PRN. I am honored to represent such a fine group of professionals. I look forward to seeing you in Texas!

***People who get on in this world are the people who get up and look for the circumstances they want, and if they can't find them, make them.***

*~ George Bernard Shaw*

Best Regards,

*Nicole*

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costs, i.e. the Asheville project. In this model pharmacists can take a role in a similar way. Pharmacists can aid in managing chronic disease states such as diabetes, hypertension and hyperlipidemia by creating optimal medication regimens and recommending appropriate laboratory monitoring of patients. Pharmacists can also aid in decreasing adverse drug events, drug interactions and potential medication errors through education of providers, staff and patients. Patient education and support is a cornerstone of this model and pharmacists are well equipped to provide instruction to patients on disease states, indications and proper usage of medication as well as the importance of regular laboratory monitoring. The PCMH provides an opportunity for pharmacists to become an integral part of the health care team and facilitate education of staff and patients.<sup>2</sup>

The Patient Centered Medical Home provides an excellent opportunity for pharmacists to become increasingly involved in patient care. While there are challenges to implementing this model it provides the opportunity to improve patient outcomes, reach patient goals and cut costs to improve the overall health care system.

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## New Standards of Care for Diabetes

By *Lea E. dela Pena, PharmD, BCPS*  
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The latest version of the American Diabetes Association Standards of Medical Care was released in January (*Diabetes Care*. 2010 Jan;33 Suppl 1:S11-61). One of the main changes for this year was the addition of the hemoglobin A1c to diagnose diabetes. An A1c  $\geq 6.5\%$  is now diagnostic for DM, while an A1c between 5.7 - 6.4% puts patients at increased risk for developing diabetes in the future (previously referred to as "pre-diabetes"). The A1c should be tested with a method certified by the National Glycohemoglobin Standardization Program (NGSP) and with an assay that is standardized to the Diabetes Control and Complications Trial (DCCT); point-of-care A1c tests should not be used for diagnosis of DM at this time. The A1c can be used as an alternative diagnostic test for the other blood tests that have been historically used: fasting plasma glucose, 2 hour plasma glucose following an oral glucose tolerance test, or a random plasma glucose along with classic symptoms of diabetes. Advantages to using the A1c for diagnosis include convenience since fasting is not required and less daily fluctuations due to acute events such as stress or illness. However, this test may be more expensive than the other diagnostic blood tests and results may not be accurate in patients with certain hemoglobinopathies, anemias, or abnormal red cell turnover; in these patients, the traditional methods of diagnosis should be used instead of the A1c. The International Association of Diabetes and Pregnancy Study Group (IADPSG), along with input from other obstetrical and diabetes organizations including the ADA, recommended that women who meet the diagnostic criteria for DM at their initial prenatal screening appointment receive a diagnosis of overt DM instead of gestational diabetes (GDM). Further recommendations from this group of experts

on the diagnosis and treatment of GDM will be forthcoming.

Another change is the consideration of aspirin for primary prevention of cardiovascular events. Recommendations for secondary prevention in patients with diabetes and history of cardiovascular disease remains unchanged with aspirin 75-162mg daily or clopidogrel 75mg daily in patients with an allergy to aspirin. However, the evidence for using aspirin for primary prevention in patients with diabetes is less clear. The ADA recommends that clinicians consider daily aspirin in diabetes patients at high cardiovascular risk, defined as a 10-year risk  $>10\%$ . This generally includes men  $> 50$  years old or women  $>60$  years old with a least an additional risk factor, including a family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria. Clinical judgment should be used for patients at intermediate risk (10-year CVD risk 5-10%), while aspirin should not be recommended in those patients at low risk for CVD (10-year CVD risk  $<5\%$ , men  $<50$  years old or women  $< 60$  years old without any major CVD risk factors). The level of evidence for using aspirin in primary prevention has been downgraded from "A" to "C".

In critically ill hospitalized patients, insulin infusion should be used to keep blood glucose levels between 140-180mg/dl, while targets  $< 110$ mg/dl are not recommended. In non-critical hospitalized patients, glucose goals are preprandial levels  $<140$ mg/dl and random levels  $<180$ mg/dl. Lower glucose goals may be acceptable in clinically stable patients who had tight glycemic control as an outpatient, while higher glucose goals may be used in terminally ill patients, those with severe comorbid conditions, or those in whom close glucose monitoring is not feasible. Insulin is the preferred agent to treat diabetes in the in-patient setting, either as an intravenous infusion (critically ill patients) or as subcutaneous injections (non-critical patients); other non-insulin medications are not recommended in the in-patient setting due to less flexibility in terms of dosing/titration and consumption of regular meals.

## Haiti Relief, One Pharmacist at a Time

The world was shocked and dismayed when the little nation of Haiti was torn apart by the earthquake that struck on January 12th, 2010. So much devastation and loss seemed incomprehensible. At the same time, though, world nations rallied to send support in all forms—people, supplies, and hope. The following, are 3 accounts of support and service provided by pharmacists during the terrible aftermath.

### An IHS Pharmacist in Haiti

*LCDR John Bearden, PharmD USPHS*

The small, impoverished nation of Haiti was literally shaken to pieces by the 7.0 magnitude earthquake that occurred on January 12<sup>th</sup> of this year. The humanitarian medical response from the Department of Health and Human Services was rapid, immense, and intricately complicated. This is my story of how I played a small but rewarding part.

I am LCDR John Bearden of the United States Public Health Service. I work for the Indian Health Service at a large outpatient clinic in Northeastern Oklahoma. I graduated with a PharmD from the University of Oklahoma College of Pharmacy in 2003. I completed a Pharmacy Practice Residency at the Choctaw Nation Health Care Center in Tahihina, Oklahoma. I've been the Pharmacy Clinical Programs Director at my current practice site for four years now. Haiti is nothing like Oklahoma.

January 27<sup>th</sup> I flew out of Tulsa at 0545 with orders to report to the Airport Sheraton in Atlanta, GA. I knew I was going to Haiti, but little else. After a brief meeting, the twelve of us were bused to the airport, boarded a chartered 737, and were "wheels up" at 2030. We landed in Haiti at around 2300 and offloaded our gear from the belly of the plane. The airport building was largely non-functional, no baggage handlers. I'd never been in the cargo hold of a 737 before.

We were met at the airport by personnel from the IRCT (Incident Response Command Team) logistics crew. It was then that we learned that most of us would be working as logistics personnel.

The logistics crew had a thankless, difficult, complicated role in the whole response picture. We moved people and things. A lot of people and loads and loads of medical supplies, tents, hand washing sinks, portable showers, portable oxygen generators, diesel electric generators etc. Everything needed to be set up, supply and maintain several field hospitals. We were to learn all this later, as none of us had been logistics personnel before.

Our primary mode of transportation was the back of a flatbed truck. No seatbelts, no seats for seatbelts. We were introduced to our first flatbed truck ride that night as we were transported to what would become our home, the American Embassy.

I'll never forget that first ride through Port Au Prince. The few miles in the dark of midnight from the airport to the Embassy revealed destruction that I had never seen on a scale so large. I've seen the path of an F-5 tornado. (Oklahoma remember.) Everything is wiped clean to the bare ground, but the damage area is limited to the path of the storm. This was different. This seemed endless. Many of the cinder block houses and buildings were shapeless mounds of rubble. Concrete, cinder blocks, and what little rebar was used to tie it all together. Much of the rubble was still spilling over the sidewalks and into the streets. Power lines hung ominously from their broken and leaning poles. This first ride was but a taste of what I would see.

The American Embassy was built in 2008 by American contractors and built to American building codes. It sustained not a scratch. The buildings literally across the street were heavily damaged or destroyed. I had never been in an Embassy building before. The security was impressive! The truck was stopped by Embassy guards and searched for explosives before entering the inner security wall of the compound. We would come to relish this security.

We spent the first night in an unused office room in the motorpool building. Twelve of us slept on the floor in a small room. At least we were indoors, had air conditioning, and a small locker room with showers and toilets.

The next day we were introduced to our civilian coworkers. Many of them had been in Haiti since shortly after the earthquake, and had already done an immense amount of work. They were really happy to get some fresh muscle as reinforcements. We soon found out why.

Let me stop here and tell you about our group of USPHS officers. None of us had ever met until that previous day at the hotel in Atlanta. We came from all aspects of the USPHS community. HRSA, IHS, FDA, CDC, and the BOP were all represented. We had two dentists, two pharmacists, two scientists, one environmental health officer, a veterinarian who was also an epidemiologist, a physical therapist, an occupational therapist, a mental health counselor, and a dental hygienist. What we lacked in muscle and logistics experience, we more than made up for in college hours and problem solving skills! Four of us had been prior enlisted military. Three Army, and me, the sole sailor in the group. This experience would prove invaluable later on as we worked closely with DOD personnel.

We spent that first day setting up what would be our sleeping quarters in the parking lot of the US Embassy motor pool. A Western Shelter 19x35 tent takes about six people who know what they are doing about 30 minutes to set up. It takes twelve people who don't know what they are doing about 2 hours under the instruction of a very patient NDMS logistics supervisor. We got a lot better at it as the days went by, because we set tents up for field hospital staff on nearly a daily basis.

We learned our jobs quickly as well. As supplies are flown into the airport, they are dropped off of cargo planes on pallets. It was our job to unload those pallets, organize the supplies on our two acre piece of ground at the end of the runway, and then move those supplies out to the field hospitals as needed. Sounds simple, right? Not so fast! Those supplies came in completely unorganized on the pallets. You may have pharmaceuticals on the same pallet with crutches and surgical equipment on the same pallet as bedpans. You get the picture.

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Speaking of pharmaceuticals! We had pallets and pallets of everything from IV fluids to throat lozenges. Many things had to be refrigerated. This necessitated a generator, which needs diesel filled every 8 hours and the oil changed periodically along with the air and oil filter. We moved pharmaceuticals from the hot, dusty airfield to the Embassy parking lot in another 19X35 tent. We were able to air condition this tent, and arrange the supplies into a reasonably organized fashion. The task was accomplished primarily by LCDR Anna Park and yours truly. It took the better part of two days and was constantly in flux as supplies came in and were moved out. We were the wholesale pharmacy for all the HHS field hospitals. As they needed pharmacy supplies, they would email their request to the IRCT Chief Pharmacist. The supplies would then be pulled, boxed, narcotics inventoried and distributed to the hospitals on the next day's resupply mission.

Resupply missions to the field hospitals were a daily occurrence. Personnel were constantly being moved out and their replacements moved in. Supplies were delivered daily, along with food, MRE's, diesel fuel for the generators, oxygen bottles, etc. It was on resupply missions that we saw most of the country in and around Port Au Prince. We saw the open air market where produce that was grown in the countryside was trucked into the city to be sold. It was NOT Wal-Mart Supercenter by any stretch!

We saw the open sewers. We saw the tent cities (if you can call sticks and bed sheets a tent). We saw the destroyed Presidential Palace. We saw the hogs, goats, and cattle wandering loose about the city, doing what hogs, goats and cattle do. I'll let you use your imagination here. We saw the Tap-Tap's (taxi's) that were nothing more than a small pickup with an elevated camper shell roof. People would crowd up to 20 in and on these. If you fell off in the road, and they did, the Tap-Tap does not stop and let you back on, nor do you get your equivalent of 50 cents back. Stoplights are just a suggestion. Lanes are just a suggestion as well. Our local drivers would fit their trucks into spaces a grocery cart would have trouble with. We had fender benders, we hit a guy on a motorcycle. We sat in 105 degree heat index for four hours in a traffic jam caused by an American celebrity on a baby- kissing- for- the- cameras mission. We saw fights between cab drivers. We were a spectacle to the locals as much as they were a spectacle to us. We smelled dead bodies. We saw dead bodies lay in the street for two days in the heat. We saw small Haitian people sorting through donated clothing from large sized Americans, trying to find something they could use. We saw children at the field hospitals that had had amputations. We saw people dying of diseases such as malaria, typhoid, and tetanus. Diseases that people here never even hear of because they are so easily preventable. We saw HIV positive newborns, just hours old and already cursed with a life that will be as short as it is difficult.

I saw something new and disturbing every day.

What we didn't see were dirty people wearing dirty clothing. I was amazed at how these people living in the worst of conditions would find whatever water they could and wash their bodies and their clothes. They would literally dip water out of the ditch into a bucket, gather naked around the bucket with a bar of soap and the whole family would bathe. They would wash their clothes the same way and hang them out to dry. I have little tolerance now for people that smell because they are simply too lazy to bathe.

We didn't see were people wallowing in self pity either. The resilience of the Haitian people was incredible. Many of the locals that we contracted with had lost everything. Some had lost their family, lost their schools, lost their workplaces, lost their churches, but not their faith in God or their willingness to work to support themselves and whatever family they had left. When we worked at the airfield organizing supplies or loading trucks, we had a select group of local people that we had working with us. When they first started, all they wanted was food and water. We gave them each an MRE and showed them how to use the flameless heaters. They would eat part of their food and save the rest. We noticed this and asked "Are you not hungry?" "I'm saving the rest for my children at home" was the reply. We made sure they and their children had plenty of food and water when they would leave at the end of each day. At the end of the week, there were tears in their eyes when we paid them for their hard work. Twenty five dollars a day is a king's ransom in a country where the average wage is two dollars a day. These people were not even aware that they were going to be paid in more than food and water.

We took care of the DOD guys that kept us safe on our resupply mission. God bless the 503<sup>rd</sup> MP Battalion! We rode with two soldiers on each truck during resupply missions. We picked them up from their camp in a dusty field, and brought them back at the end of the day. But not before we had taken them back to the Embassy so that they could get a shower and leave dirty uniforms with us. We had laundry facilities. They didn't. We would bring their clean uniforms back to them the next day. If we had time, I would take them to the small cantina in the main Embassy building and buy them burgers, a Coke and potato chips. The cantina was supposed to be off limits to us, but I didn't care and nobody said anything to me. After two weeks of MRE's, a hamburger and a Coke is something to cherish!

We flew out courtesy of the USAF and a C-130 on Feb 12<sup>th</sup> at 0224 in the morning. We arrived at Homestead AFB at around 0600 and were picked up by NDMS personnel and taken to a hotel. I'm not even sure which one it was now, but it had the worlds' greatest breakfast buffet, clean rooms, real beds, HOT showers and COLD air conditioning. I flew back home the next day.

I could write on and on about my deployment to Haiti. I'll never forget the things I saw and did, or the people I met and the friends I've made. They say a picture is worth a thousand words. This link should be worth volumes. <http://albums.phanfare.com/6999475/4580687> These are photos taken by my good friend LT Loren Rodgers, posted on the DC Area Branch of the Commissioned Officers Association web site. Enjoy.

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## Haiti Relief Effort

By Zara Risoldi Cochrane, PharmD



The hospital.



The pharmacy

On a Monday morning in January, I received an email looking for a pharmacist to volunteer with earthquake relief efforts in Haiti. On Wednesday morning, I was on a plane, facing a great deal of uncertainty, but ready to serve.

After a journey of 2300 miles, including a seven hour bus trip, I arrived at Buen Samaritano (Good Samaritan) Hospital on the border of Haiti and the Dominican Republic. Buen Samaritano was a makeshift trauma center about fifty miles from the epicenter of the earthquake in a small rural town called Jimaní. An orphanage, chapel and a same-day sur-

gery center, all still under construction, had been converted into hospital wards and operating rooms. In those first days, the hospital saw a constant influx of badly injured Haitian patients, with a census of over 450 at its peak. Until Creighton University Medical Center, my institution, sent its first surgical team, surgeries and amputations were being performed without anesthesia. As many as 75 amputations were performed in a single day. When that first group returned home, they could only describe their experience as “coffins and chaos”.

By the time I arrived two weeks after the quake, the census was down to 175 patients, there was an adequate inventory of medications and supplies, and hospital operations were much more organized. But the need for appropriate medical and pharmaceutical care was still great.

It was 6pm when I arrived at Buen Samaritano. At 7pm, I started my first 12-hour shift as the overnight pharmacist. As an academician, I was extremely nervous about working in a dispensing environment – something I hadn’t done since my clerkship rotations over two years prior. But I really believed that *any* help would be appreciated, and what I lacked in experience I would make up in hard work.

A cluttered space about 10’ x 12’, the pharmacy consisted of a small counter, a rusty sink, and several shelves. Medications that didn’t fit on the shelves were piled in corners or stuffed unsorted in cardboard boxes. Forget sterile compounding – IVs were admixed on the same counter where we ate rice and beans. Labels were handwritten with a Sharpie on masking tape. The controlled substances log was hastily scrawled on a sheet of notebook paper, and then only because the Dominican government came in and demanded we start keeping one; we had no way of locking up the narcotics.

The pharmacy was actually well-stocked with drugs. But since it relied on donations from many different groups and nations, the inventory on our shelves was sometimes surprising. We had 500 boxes of Tylenol Cold & Sinus, for example, as well as natural supplements like milk thistle and goatweed, a supply of rivaroxaban (not yet approved in the U.S.), and even a sample pack of Spanish Viagra. Doctors were amazed at the amount of propofol we had on hand. “We can’t get this stuff at my hospital!” they’d say. Of course, every time a new group of doctors arrived, I’d get requests for Precedex or Tygacil, which we simply didn’t have.

This was the central challenge I found while working in the disaster zone. On the one hand, practitioners needed to realize that we weren’t practicing medicine in the States. We didn’t have access to the equipment and technologies we were used to. With limited therapeutic options, we had to think creatively and make do with what we had: A severely constipated pediatric patient received erythromycin when we didn’t have any good options for a bowel regimen. We kept outdated phenytoin on the shelf because we had no other injectable antiepileptics. The hospital wards were exposed to the elements, and many patients had moved their beds outdoors because they were too afraid to be under a roof when aftershocks struck.

On the other hand, the difficult circumstances didn’t mean that patients shouldn’t be treated responsibly. Physicians, with the best of intentions, were prescribing antimicrobial regimens typically reserved for multidrug-resistant organisms and noscomial infections. But this population had never taken antibiotics before, never seen the inside of a hospital. At the same time, prescribers weren’t taking into account the conditions (poor hygiene, patients sleeping outside on the ground) and covering for organisms like *E. coli*.

Infectious disease was definitely an area where pharmacy had a big impact, as there was no ID physician at the hospital when I arrived. A great number of the patients were on aminoglycosides and required dosing recommendations, which we did without the luxury of serum creatinine or peak and trough levels. Prescribers sought out and were grateful for our input (and I was grateful for my Sanford Guide as backup).

Advising the nurses on administration of drugs was also an area for interventions. For instance, I had a nurse who wanted to run 1.5 grams of vancomycin over 10 or 15 minutes. I do not mean to disparage any of the selfless health care practitioners who volunteered their time, only to illustrate the importance of having our profession, as the medication experts, represented in a time of medical crisis.

After returning home, I heard more than once, “But what can a pharmacist do during disaster relief besides count pills?” In addition to dispensing, the pharmacists at Buen Samaritano Hospital were admixing parenterals, performing pharmacokinetic consultations, and making therapeutic recommendations. We carefully managed our inventory and advised on the off-label use of drugs when preferred treatments were unavailable. My daytime counterpart (Dave Ferris from Southwest General in Cleveland) rounded with the medical team by request of the ICU physicians. In short, we performed all of the activities ACCP members do every day in their own practices.

It was very hard for me to leave Jimaní: Because I was concerned about the pharmacy; the day we left, there were no pharmacists to replace Dave and me, and it was unclear who would take over our roles. Because the Haitian and Dominican people were so resilient, so full of hope in a time of despair. And because there was so much work left to do. Although Buen Samaritano has now discharged all of its patients, the rehabilitation efforts in Haiti will go on for years to come.

When we enter the profession of pharmacy, we take an oath to make “the welfare of humanity and relief of suffering” our primary concerns. I encourage you all to get involved in this kind of experience if given the opportunity. Provide care to those truly in need, whether across the world or within your own community (as I know so many of you already do). I feel very grateful to have been able to make the trip to Jimaní, and I know you will find your efforts equally rewarding.

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## My Haiti Experience – One Month After the Earthquake

Ashley H. Vincent, PharmD, BCPS

Clinical Assistant Professor of Pharmacy Practice – Purdue University  
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I had the opportunity to travel to Haiti in February 2010, about four weeks after the earthquake struck. Each year, a group of local healthcare professionals from Indianapolis, Indiana travels to a small town about five hours from Port-au-Prince to provide general medical care during a weeklong mission trip. I had volunteered to be the pharmacist for this team back in October – before there was even a rumbling of the earthquake to come. After the horrible news sunk in, the team decided to forgo the usual trip and instead remain in Port-au-Prince providing whatever aid we could. It was a hectic month of preparation – trying to find travel to get to Haiti, arranging to work with an established group in Port-au-Prince, gathering new supplies and medications to take with us, and trying to mentally prepare for what we might see. About five days before we were set to leave, it was finally confirmed that we were going to fly into Santo Domingo, Dominican Republic and then be transported to Port-au-Prince to work at St. Damien Chateaublond Pediatric Hospital with relief efforts coordinated by Nuestros Pequeños Hermanos/ Nos Petit Freres et Sceurs (NPH/NPFS).



Ashley spending time with one of her new friends

After 24 hours of travel, and very little sleep, the team arrived at St. Damien's ready to unload our donations and get to work. My first impression was that the hospital was not nearly as chaotic as I had been expecting – yes there were patients being housed in tents outside of the building and yes there were many adults being treated at a pediatric hospital – but there was also an air of calmness and control, there was food and water for the patients and family members, and there was a system in place to care for the patients. It became apparent that there was a large supply of local healthcare workers and volunteers available to help at St. Damien's so we inquired as to whether there were other places that could use our help. Our team ended up splitting up with four people remaining at St. Damien's to help with their mobile/community clinics and the remaining six members heading to a different hospital, Foyer St. Camillus, which was providing a large amount of post-operative adult care.

Prior to arriving in Haiti, I had been preparing myself to be helping with traumas... surgeries... basically wherever an extra set of hands was needed! But after arriving at St. Camillus and seeing the type of care that was in greatest need a month out from the earthquake, I was not sure how I would best be able to help as a pharmacist. There were pharmacists employed by the hospital available to dispense medications – so I was not needed in the pharmacy itself. The greatest healthcare needs seemed to be for rehabilitation, physical therapy and wound care as the patients were transitioning from a state of acute need to chronic care. There were many, many patients that had received external fixations for their broken bones requiring immobilization initially, but now needing to get up and moving and the hospital only had one, part-time physical therapist to work with both the inpatients and outpatients. Luckily, we had a physical therapist as part of our team!

I spent the first couple of days helping out wherever I could – assisting with physical therapy, getting supplies for dressing changes, providing medications during surgery, running errands or sometimes just playing with the children to distract them. I was constantly looking for some "bigger" way that I could help, feeling a little frustrated that my skills weren't necessarily being utilized to their highest capacities. Then, one evening, there was a situation that occurred that made me realize how I could contribute. A woman had been ordered ciprofloxacin IV for her infection. The pharmacy had closed for the evening and the drug had not been dispensed. After tracking down the key for the pharmacy and requesting the medication, ceftriaxone IV was provided instead. Luckily, we noticed that it was the wrong medication prior to administering it to the patient. Upon notifying the nurse that brought the ceftriaxone that it was incorrect, I received a response of "Isn't that [ceftriaxone] close enough? We hardly have any cipro but we have a lot of ceftriaxone." I was shocked to hear that sort of response from a well-educated, trained nurse, but I had found my new mission for the week! I spent the majority of my remaining time organizing the overflowing, donated pharmacy stock so that a more accurate inventory could be kept. I also created a list of what each antibiotic should be used for, as well as which antibiotics are similar and could be substituted for one another, if needed, based on medication supply.



One of the many tent cities..

Haiti has a long way to go in its journey towards recovery. Port-au-Prince remained a large tent city with food and fresh potable water in short supply. And while I may not have had the experience that I was anticipating, I can look back now and see that I was able to do some good. However small my contribution may be in the grand scheme of things that need to be done to help Haiti, I know that I at least positively influenced the care that one patient received – and will be heading back next year to help again!



Dr Tom preparing for surgery



Helping a burn victim get moving

## PRN Committee Reports

### Advocacy (Chair: Leigh Ann Ross)

The ACCP Ambulatory Care Advocacy Committee worked during the 2008-2009 year to develop a survey to be administered to the PRN to assess practice sites, billing processes, opinions regarding Medicare provider status, and advocacy practices. This survey has been completed and will be administered in 2010. This year, the Advocacy Committee is also focusing efforts on creating an overall program (e.g., mini-sabbatical) for an ACCP member to spend time with the ACCP Government and Professional Affairs team in the Washington, DC office to learn more about the advocacy process and professional affairs of ACCP. Committee members will be asked to host or participate in congressional visits at their practice sites. From these experiences, the Committee plans to provide a report on the "do's and don'ts" of hosting an elected official or staff site visit in various settings. We will continue to work with the ACCP Government and Professional Affairs office to facilitate communication to the PRN regarding advocacy issues.



### Budget & Finance (Chair: Edith Nutescu)

The Budget and Finance Committee is working to spend our money for scholarly and productive uses. We are working to increase PRN membership through offering free dues for PGY 2 Amb Care residents. This will be implemented in July 2010. We've also been working with the Research and Scholarship Committee to evaluate other methods to spend PRN funds, such as continuing the PRN seed grant. The commitment has been made to offer \$1500 for one PRN member to attend the FIT program. Lastly, the PRN will be supporting travel awards for students and residents to the Annual Meeting. (i.e. 1 student and 1 resident).



### Communications (Chair: Sarah Westberg)

The communications committee continues to sustain the ongoing tasks of completing the PRN Spring and Fall newsletters and monitoring the use of the PRN listserve. In addition, the committee has several subgroups working on the completion of the charges. One group is actively working with members of the scholarship and research committee to prepare a poster presentation from their survey results for the Fall 2010 Annual Meeting. In addition, several committee members are exploring options for novel means of communications among the PRN members, such as social networking sites. This group will be drawing from the results of the full ACCP member survey completed on this topic. Lastly, a subcommittee is reviewing the policies and procedures related to updating the Am Care Survival Guide and determining the best means to market and sell the Guide to individuals outside of the Am-Care PRN.



### Education (Chair: Mitzi Wasik)

The Education Committee is in the process of finalizing the details for programming for the Fall 2010 Focus Session at the Annual Meeting in Austin, TX. The session will focus on Updates in Antithrombotic Therapy. The committee will explore possible opportunities for collaboration with another PRN to develop focus session programming for the future.

### Networking (Chair: Daniel Richie)

The ACCP Spring Research and Networking Forum in Charlotte, NC has been scheduled for Saturday, April 24 at 12:30PM. Though there is no entertainment due to meeting time constraints, the committee has set up the education for this event. The committee assignments are set for implementation of "Walk Rounds" at the Annual Meeting. During the spring/summer, the committee will set up the education and entertainment for the Annual Meeting. In addition, the committee will be soliciting and reviewing nominations for the annual PRN Member Achievement Award.



## PRN Committee Reports (cont)

### Nominations (Chair: Allan Zillich)

The nominations committee is charged with helping to identify PRN members for ACCP awards, elected offices, and fellowship status. We are also responsible for seeking nominations for PRN offices and putting forth the slate of candidates. On March 1st, we put out a call for Ambulatory Care PRN officer positions for 2010-2011. This year, we will be electing a Chair-elect (1 year term to be followed by 1 year as PRN Chair), and Treasurer (2 year term). We would like to encourage those who are interested in nominating someone or themselves to email any member of the committee no later than 05/01/2010. Also, in May, look for a call for nominations for the Ambulatory Care PRN Achievement Award. Last year, Stuart Haines received this award.



### Scholarship & Research (Chair: Daniel Longhore)

The 2009-2010 scholarship and research committee (SRC) was active in completing several charges that included compiling results of the "Diversity and Needs Survey", ranking and funding two PRN Seed Grant applicants, and developing a funding line to partially fund an AmCare PRN member to the 2011 FIT Program offered by ACCP's Research Institute.

The "Diversity and Needs Survey" was conducted and results were compared to data from the 2003 survey. The data is being organized and will be presented jointly at the ACCP fall 2010 meeting in conjunction with the Communications Committee. Research specific needs scored low on this and a focused survey on research needs is being developed for 2010 to better understand how the PRN or ACCP can support this need of its members.

The SRC began publicizing the Seed Grant in July 2009 and received half-dozen strong applications to deliberate on. In the end, committee members agreed to partially fund two applications from Whitney Maxwell and Amy Kennedy. Two-thousand dollars has been allotted from the Budget and Finance Committee for 2010-2011 grants and notice for new applications will take place in summer of 2010. The SRC will then review, rank and fund as indicated with announcement of recipients being made late fall 2010.

The SRC has worked closely with the Budget and Finance Committee in 2009 to explore funding opportunities for the FIT Program offered by ACCP's Research Institute and they agreed to contribute 50% of tuition (\$1,625) towards the funding of one PRN member. The SRC will develop an application form in 2010 and make it available to members by the annual meeting in the fall.



### Resident and Student (Chair: Kim Thrasher)

The committee has identified Kelly Lempicki and Christie Schumacher to serve at StuNet liaisons. A subcommittee is actively working on developing activities for the Annual Meeting for residents and students. The committee is working closely with the Budget and Finance Committee to develop a plan to communicate the free dues initiatives to residents and to develop plan to sponsor a student/resident travel award. Lastly, this committee will be prioritizing a plan for the annual activities of this relatively new committee.



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The authors and editor recognize that there may be errors in this newsletter. Drug dosage schedules are, we believe, accurate and in accordance with current standards. Readers are advised, however, to check other published sources to be certain that recommended dosages and contraindications are in agreement with those listed in this newsletter.



**October 17—  
 October 20, 2010**  
 Annual Meeting  
 Austin, Texas

**April 8-April 12, 2011**  
 Spring Practice & Research Forum  
 Columbus, Ohio

**October 16—October 19, 2011**  
 Annual Meeting  
 Pittsburgh, Pennsylvania

**October 21—October 24, 2012**  
 Annual Meeting  
 Hollywood, Florida

**Ambulatory Care Recognized by BPS as a Specialty Practice**

by: Agnes Chou, Pharm.D., BCPS, CACP

In November 2008, a petition to the Board of Pharmaceutical Specialties (BPS) was submitted jointly by the American College of Clinical Pharmacy (ACCP), the American Pharmacist Association (APhA), and American Society of Health-System Pharmacists (ASHP) to recognize ambulatory care pharmacy practice as a specialty. This was something that had not been done in 18 years.

Proponents of the petition felt that ambulatory care was a subset of pharmacy practice and deserved to be recognized as a specialty. As defined in the petition submitted to BPS, 'Ambulatory Care Pharmacy Practice is the provision of integrated, accessible healthcare services by pharmacists who are accountable for addressing medication needs, developing sustained partnerships with patients, and practicing in the context of family and community. This is accomplished through direct patient care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self management.'

Below, is a brief timeline which provides an overview of the laborious process.

Timeline

- Nov 2008** Petition to BPS requesting recognition of Ambulatory Care Pharmacy Practice as a specialty was submitted (96 pages)
- Dec 2008** Open Hearing ASHP Midyear Clinical Meeting, Orlando, FL
- April 2009** Open Hearing APhA Annual Meeting San Antonio, TX
- April 2009** Open Hearing ACCP Spring Meeting Orlando, FL
- June 2009** Petition was approved
- Nov 2009** The newest specialty held their first council meeting
- Jan 2010** BPS seeks item writers for the BPS Ambulatory Care Exam
- Oct 2011** First BPS Ambulatory Care Exam will be administered

The Open Hearings held at ASHP, APhA, and ACCP meetings served as a forum where pharmacists from various specialties were encouraged to voice their opinions—either for or against establishing Ambulatory Care as a separate specialty.

Some clinicians felt that the specialty credential in ambulatory care would further subdivide the profession, and this may weaken, rather than strengthen, our profession's quest for recognized provider status. On the contrary, other practitioners felt that this would be beneficial for those with specialty practices within ambulatory care. Certification could serve as a foundation for medication therapy management reimbursement, as well as reimbursement for other clinical services.

An interesting question brought up at one of the open hearings was whether now the pharmacotherapy exam will continue to include ambulatory care questions, or will the focus shift more towards acute care or critical care. Also, for those practitioners who already have BCPS, will they be encouraged to keep and maintain both certifications? Certainly, that would be a financial burden and also would lead to time constraints. Will they be required to choose one over the other. How will they decide which one is better?

No matter what your opinions are about this issue, we can all agree that ambulatory care pharmacy has come a long way. The petitioners' efforts were not wasted. It was a long and grueling process, but finally, on June 12, 2009, the Board of Pharmaceutical Specialties (BPS) unanimously approved the petition requesting recognition of ambulatory care pharmacy practice. Ambulatory care pharmacy practice has now joined the ranks of 5 other specialties that have been recognized by BPS:

- Nuclear Pharmacy --1978
- Pharmacotherapy--1988
- Nutrition Support Pharmacy--1988
- Psychiatric Pharmacy--1992
- Oncology Pharmacy--1996

**Contents of the ambulatory care specialty exam will include:**

<b>Domain 1</b>	<b>Direct Patient Care</b>	<b>50% of exam</b>
<b>Domain 2</b>	<b>Practice Management</b>	<b>20% of exam</b>
<b>Domain 3</b>	<b>Public Health</b>	<b>5% of exam</b>
<b>Domain 4</b>	<b>Retrieval, Generation, Interpretation and Dissemination of Knowledge</b>	<b>15% of exam</b>
<b>Domain 5</b>	<b>Patient Advocacy</b>	<b>10% of exam</b>