

# Creation of a certification requirement for pharmacists in direct patient care roles



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**Purpose.** Steps taken by a large health system to require certification for all pharmacists in direct patient care roles are detailed.

**Summary.** Major supply chain changes and rising payer expectations are reshaping pharmacy practice, resulting in expanded responsibilities for pharmacists and a heightened need for certification in specialized practice areas. In response, the pharmacy leadership team at UW Health, the integrated health system of the University of Wisconsin–Madison, used an iterative process and a “rolling” FAQ format to develop and implement a certification requirement. Key decisions during the process included decisions to accept only rigorous certifications (mainly those offered by the Board of Pharmacy Specialties), to provide institutional support for continuing education–based recertification, and to use an accepted definition of direct patient care in determining which pharmacists need to be certified. The team obtained the support of the UW Health human relations department by drafting a policy and rewriting all pharmacist position descriptions to incorporate the certification requirement. An all-pharmacist forum was held to build staff commitment. As a result of the requirement, 73 pharmacists were required to obtain certification by 2018 at a total cost to UW Health of \$44,000; ongoing support of certification maintenance will cost an estimated \$40,000 per year.

**Conclusion.** Health systems can be successful in establishing uniform certification expectations for pharmacists in direct patient care roles, even across diverse practice settings, by aligning expectations with organizational goals.

**Keywords:** certification methods, certification standards, continuing education, staff development

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Changes in the healthcare landscape have created both opportunities and challenges for the profession of pharmacy. The promise of provider status, expansion of pharmacists' scope of practice, increasing complexity of medication therapy, increasing pressure on medication distribution channels, and increased numbers of physician health-system executives are a few of the major forces shaping pharmacy practice.

Health systems are using collaborative practice to address these challenges, optimize patient care, improve outcomes, and control costs. With these

advances in pharmacy practice come greater responsibility and the need for proof of competence through credentialing. This article describes the steps taken by UW Health, an integrated health system located in Madison, to require certification for all pharmacists in direct patient care roles.

## Problem

Pharmacy is not the only profession expanding its patient care role. Although the number of pharmacy school graduates increased by 76% from 2002 to 2014,<sup>1</sup> there was 164% growth in the pool of nurse practi-

tioner graduates and an 89% increase in the number of physician assistant graduates during the same period.<sup>2,3</sup> As medicine continues to advance and patients become more complex, pharmacists will increasingly be required to prove that they are competent to manage these patients and their medication regimens alongside their inter-professional colleagues. The pharmacy profession must not just claim but demonstrate and be accountable for advanced clinical expertise, the ability to improve medication adherence, and the capacity to both monitor and improve patient outcomes.

Health systems are transitioning to greater numbers of physicians serving as chief executive officers and top-level executives, and physicians are comfortable with the idea that certification is the way to demonstrate knowledge and ability beyond degree education because they are themselves required to obtain certification to prove their competence. Physicians in general support the expansion of pharmacists' scope of practice, with 2 exceptions. First, they do not think pharmacists should have independent prescribing authority, and second, they think pharmacists should not be able to make diagnoses.<sup>4</sup> In a publication about pharmacists' scope of practice, representatives from the American College of Physicians and the American Society of Internal Medicine indicated that a Pharm.D. degree does not provide a sufficient level of training and experience to make the most appropriate medication-related decisions for patients.<sup>4</sup>

There are also ongoing changes in the channels of medication distribution due in large part to the high costs and complexities of the new drugs coming to market. Limited-distribution medications are becoming increasingly common, and their use requires that pharmacies provide a high-impact service for patients through clinical interventions, patient monitoring, tracking, and reporting. These changes pose significant threats to retail, community, and hospital

### KEY POINTS

- Voluntary approaches, however robust, are unlikely to achieve universal certification of pharmacists in direct patient care roles.
- Uniform expectations for all pharmacists in direct patient care roles—regardless of practice type—can be established.
- Use of an iterative process that includes pharmacy leadership team consensus building, organizational consensus building, a thoughtful communication plan, and response to feedback can improve staff acceptance of a certification requirement.

outpatient pharmacies.<sup>5</sup> A survey of an expert panel for the ASHP Research and Education Foundation's *Pharmacy Forecast 2014–2018* report found that 43% of respondents thought it “somewhat likely” and 24% thought it “very likely” that the number of drug products available through specialty pharmacies and closed-distribution channels will increase by at least 75%.<sup>6</sup> To maintain the ability to dispense these medications to patients, pharmacists will need to demonstrate in a systematic manner that they are qualified to monitor patients taking these medications, improve adherence and clinical outcomes, and reduce the cost of care for insurers. As pharmacists continue to become an increasingly visible part of the healthcare team, both patients and insurance companies, as consumers in the healthcare marketplace, will be interested in knowing which pharmacists are most capable of managing medications and improving outcomes. Pharmacists must be able to effectively communicate and advertise their value to maintain quality ratings and position themselves to secure preferred net-

work status and pay-for-performance rewards.

Given these forces, the need for certification has never been higher. The Board of Pharmaceutical Specialties, now called the Board of Pharmacy Specialties (BPS), was created by an American Pharmacists Association task force in 1976, and the American College of Clinical Pharmacy endorsed board certification in 2006, followed by the American Society of Health-System Pharmacists (ASHP) in 2011. The number of BPS-certified pharmacists reached 13,000 in 2013, and the goal is to reach 30,000 in 2017.<sup>7,8</sup> There are currently 8 different BPS certifications, including ambulatory care pharmacy (denoted by the designation BCACP), oncology pharmacy (BCOP), nuclear pharmacy (BCNP), pharmacotherapy (BCPS), nutrition support pharmacy (BCNSP), psychiatric pharmacy (BCPP), pediatric pharmacy (BCPPS), and critical care pharmacy (BCCCP). BPS confers “added qualifications” in cardiology and infectious diseases and is evaluating the role of board certification in the areas of sterile compounding, solid organ transplantation, and emergency medicine.<sup>7,8</sup> As the value of certification continues to grow, so too has the number of certifications available to pharmacists.

Health systems and professional pharmacy associations are increasingly encouraging board certification for their pharmacists. Many residents interviewing for jobs are finding that certification is either required or expected within a certain time period after hiring. Although some pharmacists exploring board certification remain skeptical about whether the benefits outweigh the time and financial commitment, 96% of board-certified pharmacists surveyed in 2011 reported that they felt certification was valuable; 74% claimed that they had gained personal satisfaction by accomplishing something professionally important, 63% believed they had acquired expanded knowledge and skill, and 39% said they had attained greater

credibility as a professional.<sup>8</sup> Certification not only enhances personal and professional satisfaction; a study found that process-of-care measures for patients with acute myocardial infarction and heart failure were significantly improved at hospitals where 1 or more pharmacists had added qualifications in cardiology versus matched hospitals without pharmacists with added qualifications.<sup>9</sup> Patients, physicians, employers, and insurers are all becoming more aware of the value of pharmacist certification. If the pharmacy profession wants to continue to expand practitioners' scope of practice, pharmacists in all practice settings must be not only willing but eager to demonstrate their competence and accountability through certification.

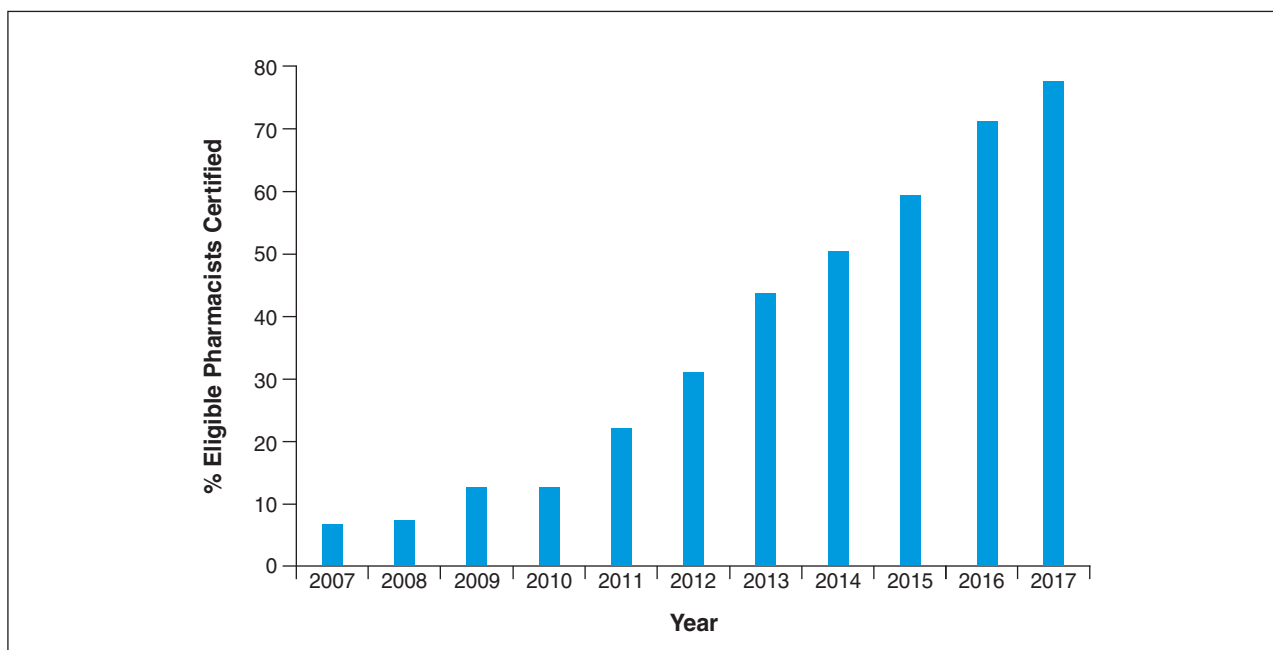
### Background

The path to a pharmacist certification requirement was a 5-year journey of building expectations, starting with the launch of the ASHP Pharmacy Practice Model Initiative (PPMI) in 2011. Pharmacists were at the time,

and remain, positioned throughout UW Health—in ambulatory care, inpatient care, drug policy, pharmacy benefit management, and many other areas. Given the national attention the PPMI was generating in the months after its launch, an internal PPMI retreat was convened, and the result was a global practice model vision statement, with a goal of full practice model realization by 2015. Later in 2011, a follow-up survey was issued to all pharmacists to assess the importance of these goals and the progress to date. The results of this survey found that a slight majority of UW Health pharmacists believed that a credentialing and certification goal was important and was, at that time, achieved “sometimes” within our department; a gap existed between the perceived importance and actualization of this aspect of the vision statement. During the period 2011–13, a Pharmacist Advancement and Recognition Program was developed and implemented. This program included certification as a criterion for advancement and a requirement to achieve the highest

level of recognition in the program. In late 2013, a goal of having all UW Health pharmacists in direct patient care roles certified by December 31, 2015, was disseminated to all pharmacists at a staff meeting. The presentation described the history of pharmacist board certification, described parallels with physician certification development, described the growth in numbers of certified pharmacists, reviewed data on the benefits of certification, gave credit to the pharmacists who were already certified, and provided certification resources and instructions for the next steps needed (e.g., how to register, study group information). During this time, support for certification included facilitated study groups focusing on the most commonly obtained certifications and reimbursement for 50% of examination costs for UW Health pharmacists receiving a passing score. While from 2011 through 2015 no requirement for certification was in force, the proportion of certified pharmacists grew from 12.6% in 2010 to 59.3% in 2015 (Figure 1). Consistent messages about

**Figure 1.** Growth of pharmacist certification at UW Health, 2007–17.



the importance of certification were issued.

### Analysis and resolution

**Building leadership team consensus.** Starting in May 2015, as the ambulatory care leadership team was growing the oncology and specialty pharmacy services, the team encountered insurance contracts requiring pharmacist certification as a method of ensuring a qualified and competent staff to manage high-cost, high-risk medications. With this new incentive the leadership team agreed to pursue a certification requirement, and a pharmacy resident and a small group of leadership team members representing inpatient and ambulatory care pharmacists were tasked with making a proposal to bring back to the leadership team.

The work group began by crafting a FAQ document based on the questions posed by the leadership team and developing proposed answers. This format allowed for ongoing documentation and refinement of both global questions such as “Why is the department now pursuing a requirement for certification?” and more granular and operational questions such as “What happens if a pharmacist fails the certification exam?” This periodically updated list of questions and answers was refined from June through September 2015 by the work group, which was led by a pharmacy practice resident who was on an administrative rotation at the time. Input was gathered monthly from the entire leadership team.

There were 2 key ideas that served as the basis of the certification requirement. First, the value of certification to an organization is not necessarily in the credential itself; with ongoing requirements for recertification (every 7 years) and credential maintenance (100–120 hours), pharmacy leaders decided that a certification requirement could help assure that low-quality continuing-education content was replaced with rigorously evaluated BPS-approved content.

Second, it was decided that we must require only the most rigorous certifications. Certification is an industry, and the quality of each credential varies widely. The leadership team’s opinion was that BPS-conferred credentials were the “gold standard” for 3 main reasons. First, they are the most widely recognized by payers, patients, providers, and pharmacists. Second, BPS examinations are validated and, with initial pass rates of 60–70%, clearly rigorous.<sup>7</sup> Third, the breadth of the material covered by the BCPS certification, with 45% of content related to drug information, evidence-based medicine, systems standards, and population health, makes it applicable to almost any practice area—important for establishing a broad requirement. The leadership team additionally supported multiple BPS subspecialty certifications that align with our key service lines (i.e., the BCOP, BCPS, and BCACP credentials).<sup>7</sup> The only non-BPS certifications that were considered appropriate for inclusion in the UW Health program were the certified specialty pharmacist (CSP) designation conferred by the Specialty Pharmacy Certification Board and the Certified Anticoagulation Care Provider (CACP) designation conferred by the National Certification Board for Anticoagulation Providers. CSP certification was approved because of its relatively high maintenance requirements (continuing education in specialty pharmacy and continuous development planning), rigor (a 68–75% pass rate), recognition by payers, and the uniqueness of the practice area.<sup>10</sup> CACP certification was approved because of its relatively high maintenance requirements (re-examination every 5 years, continued compilation of professional experience hours) and the absence of another option for pharmacists who only work within anticoagulation clinic practice.<sup>11</sup> The decision to include the CSP and CACP certifications in the UW Health program would likely be reevaluated if equivalent BPS certifications were offered.

Once the leadership team understood the value of certification and the available options, the next major area of discussion was which pharmacists would be required to obtain certification. It started as a requirement for all pharmacists regardless of practice area. Discussion then transitioned to a focus on pharmacists involved in direct patient care activities. There was debate about the nature of the term *direct patient care* and how broadly it should be interpreted. Whether or not prescription filling or sterile product verification constitutes direct patient care was an area of contention. Instead of creating an institutional definition of direct patient care, it was determined that the BCPS eligibility criteria should be used, as they were already generally accepted. The BCPS certification eligibility requirements stipulate that 50% of a candidate’s time be spent on patient-specific pharmacotherapy (i.e., collecting patient data, interpreting those data, and designing therapeutic plans and implementing them in collaboration with other healthcare professionals) or in the previously mentioned domains in evidence-based medicine pharmacotherapy and systems pharmacotherapy.<sup>7</sup> This stipulation allowed for flexibility of interpretation, allaying any fears that pharmacists working in the area of sterile product preparation or overnight positions without direct patient care responsibilities would leave the organization as a result of a certification requirement.

**Building organizational consensus.** With the FAQ document finalized and the leadership team in agreement, the proposed certification requirement was then taken to the human relations (HR) department for vetting; this helped ensure that we had buy-in and that the requirement was aligned with those for other professionals in the organization who had similar requirements (advanced practice providers). The HR department was supportive and requested 3 follow-up items: a specific policy

outlining the requirement, a description of the communication plan, and revised position descriptions with updated minimum qualifications that included certification. Approval of the concept, communication plan, and certification policy language was obtained in September 2015, and the details of the final policy and position descriptions were all redrafted and approved prior to the requirement being instituted.

**Building staff commitment.** The final phase of implementation was communicating the certification requirement to the entire pharmacist staff. The decision was made to present the information to all staff at a “forum” to control the message and ensure it was optimally delivered. The goal was to create space for pharmacists to respond directly to the pharmacy department leadership with their concerns. There were concerns that the forum could devolve into unproductive discussions, but ultimately it was decided that with the director at the front of the issue supporting certification, this was an unlikely outcome. To start, the director of pharmacy issued an e-mail to all pharmacists about the forum and its importance to the future of our department. The director of pharmacy then held each manager accountable for ensuring attendance by their direct reports and set the expectation that very few exceptions would be tolerated. Any pharmacist who was not present at the forum would be required to meet one-on-one with his or her manager to receive the content. The forum discussion was recorded so as to be shared with those who were not able to attend in person during subsequent one-on-one meetings. The presentation was structured into 4 sections: (1) the forces in healthcare and the profession driving the new requirement, (2) the history, future, and value of certification, (3) the connection with the department’s mission and vision, and (4) the proposed policy language, ending with a review of the FAQ content. All questions were noted, and proposed

answers were recorded for potential inclusion in FAQ document revisions. In total, 84 pharmacists attended the forum in person and 17 participated via webinar. Overall, feedback on the forum was positive. Pharmacists felt like space was created for them to hear the “why” behind the impending policy change.

Pharmacists were encouraged to provide feedback regarding the proposed policy change after the forum. Some provided feedback via e-mail, while others communicated with managers during one-on-one meetings. There were 3 common feedback themes: the initial timeline proposed was too short, the costs to obtain and maintain certification would be prohibitive, and the time required to prepare for the initial certification and maintain certification would negatively impact a healthy work–life balance.

**Responding to concerns.** Each piece of feedback received was shared with the leadership team for further discussion. As a result of feedback from pharmacists, the deadline for certification was extended by 1 calendar year for the majority of pharmacists. Exceptions to this change, which were based on known contractual obligations, included pharmacists practicing in ambulatory care oncology and specialty pharmacy settings. Collaborative efforts with HR personnel resulted in financial compensation for the entire cost of the initial certification exam. Furthermore, it was projected that maintenance costs for certification would be offset by annual reimbursement for ongoing continuing-education costs and maintenance fees. These changes were added to the FAQ document, and the certification policy was updated. Updates were shared with pharmacists across the entire department less than 2 months after the initial certification forum.

**Impact of the certification requirement.** Based on the definition set by the pharmacy management team for this requirement, a total of

127 pharmacists across the organization will need to achieve certification. At the time of policy implementation, 54 pharmacists previously required to do so had already achieved 1 or more certifications that met the new requirement, and an additional 9 pharmacists who were not previously required to do so had nonetheless earned qualifying certifications. This left 73 pharmacists who are required to be certified by the end of 2018.

The certification requirement’s financial impact on UW Health has included a one-time cost of approximately \$44,000 to reimburse newly certified pharmacists. This cost has been spread over a 3-year time frame as a result of the 2018 certification deadline. Under the previous policy, the reimbursement cost averaged \$2,400 per year to reimburse for new certifications at half the cost of the examination at the time a certification was obtained. Additionally, under the new requirements the organization will spend approximately \$40,000 per year in certification maintenance support for those pharmacists who are identified as among those required to achieve certification. The financial implications for the organization will depend on department staffing fluctuations and on how many new pharmacists who do not already have an approved certification are hired, but the associated costs are expected to vary minimally from year to year. Additionally, as new certifications become available in pharmacy practice areas for which advanced certifications are not currently available, the number of certified pharmacists will grow, and that will have financial implications.

The policy change allows for a consistent message to pharmacists interviewing for open positions in direct patient care settings regarding the pharmacy department’s stance on advanced certifications. During the recruitment and interview process, the policy highlights a consistent expectation for UW Health pharmacists to practice at an advanced level.



Additionally, securing initial and ongoing financial support from the organization has emphasized to prospective pharmacists the leadership perspective that certification maintenance provides benefit with respect to a rigorous and high-quality process to keep pharmacists up-to-date with the most current patient care guidelines and practices.

## Discussion

There are multiple forces acting on the profession of pharmacy that should induce each of us to consider the role certification will play in our future roles as integral members of the patient care team. Pharmacy leaders should examine how their organizations are setting expectations for their pharmacists. Regardless of the size of the organization, the importance of setting expectations for pharmacist certification must be recognized and driven home by those in pharmacy leadership positions, communicated to pharmacists in direct patient care roles, and shared with leaders outside of the pharmacy department. Raising expectations for ourselves as professionals will translate into higher expectations by our patients, our colleagues, and society.

Calls for broader requirements for pharmacist certification could originate from any part of the pharmacy enterprise. Each organization should take time to evaluate the variety of certifications available. Thorough discussion and evaluation by leadership teams will help identify which certifications align with patient populations, care settings, and organizational needs. Creating a unified expectation for certification that is inclusive of all sites of care will elevate practice expectations and ensure consistent messaging from the leadership team. Throughout this process, a standard approach to evaluating certifications and clearly communicating this method will improve staff acceptance and form the basis of assessment for new certifications as they become available.

Additionally, organizations should evaluate what resources they may have available to support pharmacists in this endeavor even when direct financial incentives are not available. Support could also take the form of assisting pharmacists in the preparation process by developing a study schedule or coordinating review sessions. When possible, content experts within the organization should be identified to lead designated study sessions or partner with content experts from outside organizations via conference calls or video technology. Staff should be encouraged to use study materials to target students and residents for prerotation readings or to help trainees prepare for topic discussions so that they can master the content and gain confidence in passing a certification examination.

In the future, requirements for pharmacist certification could lead to a broader strategy for pharmacist credentialing and privileging. When new roles for pharmacists within our organization have been identified—for example, in primary care—being able to assure physician leaders that our staff is highly competent has eased concerns. Physician leaders can then see the parallels with certification of advanced practice providers and their own credentialing process; at UW Health, such leaders have worked to advance discussions with the medical board and other stakeholders to pursue formal pharmacist credentialing and privileging for staff in specific practice areas. These pharmacists could begin an organizational push for credentialing and privileging for all pharmacists.

## Conclusion

Health systems can be successful in establishing uniform certification expectations for pharmacists in direct patient care roles, even across diverse practice settings, by aligning expectations with organizational goals.

## Disclosures

The authors have declared no potential conflicts of interest.

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