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An Open Letter to ACCP Members:
ACCP's Board Certification Quandary

(Editorial note: After composing this lengthy letter, I realized that it might have been helpful to provide an executive summary that concisely presents the major points of my message. However, I elected not to provide such a summary because I feel that the details surrounding this issue are too important to be distilled down into a brief abstract. Hence, I respectfully ask anyone truly interested and concerned about the future of clinical pharmacy specialization and board certification to read the entire contents of this letter. JET)

May 24, 2010

Dear ACCP Member,

I am writing this letter to update you on ACCP's recent efforts to work with the Board of Pharmacy Specialties (BPS) to examine how the profession might develop a contemporary, strategically designed framework for specialist certification that better accommodates the growing number of specialist and subspecialist pharmacists, many of whom are ACCP members. To be honest, as described below, our efforts thus far have not been successful. But, as noted at the end of this letter, we have not given up. Indeed, we have only just begun to advocate aggressively for substantial change in the manner in which the profession certifies clinical pharmacy specialists and subspecialists. *(For additional perspective on the comments below, please see the Brief History of relevant chronological details that help illustrate how this quandary has unfolded.)*

Why Is ACCP Concerned About the Current Specialist Certification Framework?

We are concerned about the current process for pharmacist specialist certification because we believe it fails to meet contemporary societal or professional needs. I think we would all agree that patients benefit from the care of clinical pharmacist specialists/subspecialists. However, without an accessible, defensible, coherent, and efficient framework for recognizing clinical pharmacy specialties and without certifying more clinical pharmacy specialist/subspecialist practitioners, many patients will not receive the levels of pharmacotherapeutic care they need and deserve. In addition, patients for whom we care and other health care professionals with whom we collaborate will have no means of ensuring the competency of the clinical pharmacists who provide advanced levels of pharmacotherapeutic care. This inability to recognize the full spectrum of clinical pharmacy specialists and subspecialists leaves patients, health care providers, payers, and employers both mystified about our profession's approach to specialization and unable to take full advantage of the contributions these practitioners make to patient care.

ACCP began discussions with BPS in 2004 regarding a perceived need to think strategically about the future of specialist certification (see the Brief History). At the time, there was growing interest in some circles for establishing an Ambulatory Care/Primary Care specialty certification. ACCP was concerned not only about how this new specialty was to be defined, but also about the number of specialists/subspecialists practicing in other areas for which BPS certification was not available. Although the "added qualifications" (AQ) designation under the Pharmacotherapy specialty is intended to help meet the needs of some of the specialists and/or subspecialists practicing in an area where a specialist certification does not already exist, the AQ designation has not been widely embraced by current clinical pharmacy specialists/subspecialists. Even though the reasons for this lack of widespread acceptance remain unclear, clinical pharmacist colleagues who have shared their opinions with me have generally expressed the notion that the AQ requirements (essentially assembling a portfolio) are not sufficiently rigorous and that the AQ designation is not understood by or easily explained to colleagues in other health professions. When asked by my own medical colleagues whether the "BCPS (AQ Cardiology)" in my professional title means that I've passed a cardiology pharmacotherapy board examination similar to a physician's cardiology board examination, I have to confess that such is not the case.

ACCP Member Survey Regarding Board Certification

In summer 2006, to determine the opinions of ACCP members regarding the need to establish new specialties, the College conducted a survey of ACCP members, asking (1) whether the BPS pharmacotherapy specialty certification (BCPS) is the appropriate credential for most clinical pharmacy practitioners, regardless of practice setting (inpatient/acute care, outpatient/ambulatory care); (2) whether new BPS specialty certifications (not AQ within a specialty) are needed to appropriately certify clinical pharmacy practitioners in areas other than Pharmacotherapy; and (3) if new BPS specialty certifications are offered, would one likely choose to become certified in one or more of these new areas. About 1300 ACCP members responded to that survey; 49% were currently board certified, and 51% were not board certified. Although 84% of board-certified and 64% of nonboard-certified respondents felt that the Pharmacotherapy specialty was the appropriate credential for most clinical pharmacy practitioners, only 31% of certified respondents and 20% of noncertified respondents felt that no board new certifications were needed. In addition, in indicating which specialties were needed, between 20% and 54% of respondents selected one or more specialty areas, with Critical Care, Pediatrics, and Infectious Diseases leading the way. The results of this survey were shared with the ACCP membership at the Business and Town Hall Meeting during the ACCP Annual Meeting in St. Louis on October 26, 2006; BPS staff were in attendance at that Town Hall presentation. Based on the survey data and discussions during the Town Hall session, the Board of Regents (BOR) clearly understood that ACCP members wanted and needed more options for specialist certification.

Time and Cost Required for Establishing New Specialties in the Existing System

Another concern of the College about the current framework for pharmacy specialties is the onerous effort and cost associated with establishing a de novo specialty. Although not widely known, the work and expense currently involved in establishing a completely new specialty under the current framework are enormous, both in time and resources. As gleaned from the Brief History, efforts to establish the new specialty in Ambulatory Care were launched formally in May 2006. This new specialty is expected to offer its first examination in October 2011. That is, the process from start to finish will have consumed more than 5 years. Furthermore, the process required resources from BPS (which

financed the task analysis) and three cosponsoring organizations (ACCP, APhA, and ASHP), which totaled more than $150,000 just to *establish* the specialty. Costs for examination development will add substantially to this amount—BPS estimates that this will add another $150,000 to the expense. If more than 5 years and $300,000 (in 2010 dollars) are required to establish each de novo specialty, at least 45 years and a substantial cash investment will be necessary to establish the nine (or more) additional specialty certifications believed to be needed by the ACCP members responding to the 2006 survey.

But, some might ask, perhaps more than one specialty could be developed concurrently, thereby shortening the time span? Of course, this is possible, provided that (1) BPS can manage and finance the task analyses and other steps in the specialty development process on a more frequent basis and (2) enough sponsoring organizations (including smaller specialist pharmacist organizations, PRNs, or others) will have the resources available to allocate the estimated $100,000 or more needed to develop a specialty petition in accordance with the current BPS framework. Neither seems likely. (To illustrate the work involved in petition development, see the 96-page Ambulatory Care Specialty Petition submitted to BPS and the 886 pages of the petition's appendices). BPS has now declared interest in developing a new specialty in Pediatric Pharmacotherapy (see BPS Letter); if efforts begin this year to establish this specialty, the first specialty examination will likely be offered no earlier than 2015. This timeline also assumes that well-capitalized sponsoring organizations will be in the wings, ready and able to commit the resources needed to develop the petition recognizing Pediatric Pharmacy Practice as a specialty for submission to BPS.

Seeking a More Efficient and Credible Board Certification Model

In our view, a new certification framework that relies on the foundational pharmacotherapeutic and related knowledge common to all clinical pharmacy specialties/subspecialties, and that subsequently builds on this common foundation by adding the specific knowledge domains that apply to a given specialty, would provide a much more coherent and efficient basis on which to develop the profession's future clinical specialty/subspecialty petitions. A framework that more closely emulates the multipart medical model of board examinations is desirable because it could logically be matched to the profession's current PGY1 and PGY2 training models. That is, PGY1 graduates could become certified by completing the foundational knowledge examination and thus be recognized as clinical specialists at that level. Those who complete additional clinical training (for example, a PGY2 specialized residency) could then take a second, more focused certification examination to achieve recognition in that specialty or subspecialty. Groups that submit petitions and develop examinations for the second examination would not have to "reinvent the wheel" and address the general therapeutics domain; they would only need to focus on their respective specialized domains. Such a model makes much more sense than the current model, not only with respect to requiring a broad base of therapeutic knowledge and experience before addressing specialty/subspecialty domains, but also because patients, physician colleagues, and payers are familiar with this model, as it emulates the medical model for training and specialist recognition.

Of course, some specific issues would need to be addressed. What will happen to current BPS-recognized specialists who were credentialed in the current model? We would suggest that their existing certifications be fully recognized as equivalent to the new, post-PGY2 certified specialist/subspecialist. They would then have to be recertified in their respective specialty (by methods similar to current recertification processes, but, it is hoped, by methods more streamlined and cost-efficient) to maintain their certification. What will happen to the current Pharmacotherapy specialists? In our view, they will be

considered equal to Pharmacotherapy specialists in the new model and will be recertified periodically using the same recertification processes described above. What designation will be assigned to those who complete PGY1 training and the foundational knowledge examination described earlier? Such a decision should be left to the certifying body and the profession. If asked, we suggest "Board Certified Clinical Pharmacist" or something similar, as long as it does not carry the same designation as one of the existing BPS specialties. Obviously, much work and deliberation are ahead—we provide the foregoing template only to illustrate, in concept, a vision for this new framework and its rationale.

Encouraging Profession-Wide Discussion of Certification Framework

Based on the foregoing, ACCP has been encouraging BPS to gather profession-wide input and promote dialog on needed changes in pharmacy's current specialist certification framework. Unfortunately, despite more than 5 years of meetings, e-mails, and letters, we have been unable to convince BPS of the merits of this viewpoint. Although ACCP has advanced one possible approach to configuring a new framework (as described above; see also the ACCP White Paper on this subject), we have not been dogmatic in advancing this view. Indeed, what we have encouraged is the convening of a stakeholders meeting to examine this issue at the profession-wide level. We envision a strategic conference that will seek input from the practitioner community, including the organizations that represent many of today's clinical specialists and subspecialists. We hope that such a meeting will bring together not only the primary national pharmacy practitioner associations, but also the specialist/subspecialist organizations (such as CPNP, HOPA, PPAG, SCCM, SIDP, and others[1]) that have played major roles in the professional development and evolution of clinical pharmacy specialists. However, this issue is instead under consideration by the Council on Credentialing in Pharmacy (CCP), a body in which ACCP is represented, but one that lacks formal membership of any of the specialist or subspecialist organizations mentioned above. Because ACCP is one of only a handful of CCP member organizations focused on pharmacy specialist certification, the concerns expressed above are unlikely to receive the degree of attention within CCP they would be accorded by a dedicated stakeholders conference.

Why Did ACCP Support the New Ambulatory Care Certification Rather than Working Toward Establishing a New Certification Framework?

In making the decision to collaborate with APhA and ASHP in the exploration of establishing a new Ambulatory Care specialty, the ACCP BOR clearly stated that its attention would not be diverted from the overarching priority of addressing the need for a new approach to specialist certification. In ACCP's letter to BPS on May 23, 2006, in which the College committed to participating in a joint ACCP-APhA-ASHP task force to explore the feasibility of a new Ambulatory Care specialty, ACCP stated, "We remain very interested in the BPS vision for a future certification framework that would best serve the profession. Toward that end, we would like to arrange for representatives of the ACCP Board of Regents to meet with representatives of the BPS leadership to engage in some frank discussion of this subject in the near future." Such a meeting did eventually occur, but not until late 2009, more than 3 years later (see Brief History).

The BOR gave careful consideration to the differentiation of Ambulatory Care from Pharmacotherapy as a distinct specialty. The task analysis conducted under the auspices of BPS, and evaluated by the joint ACCP-APhA-ACCP task force, led the BOR to agree that Ambulatory Care was

indeed a unique specialty as currently defined by BPS. With that question answered, the College's next task was to determine whether it should serve as a co-petitioner for the specialty. In view of (1) ACCP's commitment to promoting the expansion of specialist certification, (2) the number of ACCP members practicing in the ambulatory care environment who desired a new and different specialist certification, and (3) the College's desire to ensure that the rigor of the new specialty examination would be commensurate with that of the Pharmacotherapy specialty examination, the BOR reached the decision that ACCP should serve as a co-petitioner together with APhA and ASHP.

At the same time, as noted above and in the Brief History, ACCP continued to pursue with BPS the idea of building a professional consensus on a more optimal specialist certification framework. This was carried out with the perhaps naïve expectation that a reevaluation of the framework could be considered concurrently with the development of a new specialty. ACCP believed that BPS discussions surrounding some of the overlap in knowledge domains of the Pharmacotherapy and Ambulatory Care specialties, together with the ideas advanced in the College's 2009 White Paper, would illustrate the need for a new approach to specialist certification. However, such was not the case.

What Will Be the College's Next Steps?

ACCP applauds BPS's efforts to increase the number of pharmacy specialties and to provide clinical pharmacists practicing in heretofore unrecognized specialty or subspecialty areas access to specialist certification. To the best of its ability, ACCP will continue to support these BPS efforts. *However, these efforts are insufficient to address the lack of a coherent certification framework and the time and expense required to develop new specialty certifications*. Simply stated, the current specialist framework and associated processes for recognizing a new specialty are too cumbersome, protracted, and inefficient to meet the profession's current and future specialist certification needs. Furthermore, seeking to advance specialist recognition for a few specialties now (see BPS Letter), without first establishing a more efficient and coherent framework, will involve costs for petition development and task analysis that are beyond the reach of most professional organizations. For one or more of the larger national organizations, even if they have the resources to sponsor a plethora of new specialties, determining which specialty/subspecialty group of practitioners will be supported first may be an unsolvable political dilemma. For example, how should ACCP decide which group will be considered now, and hence rewarded with an examination in 5 years, and which specialty area will have to wait 45 years for recognition?

Clearly, the existing framework and processes for specialty recognition must change. The current linear "one-and-done" approach to recognizing specialists, and the absence of a coherent and accessible process for recognizing subspecialists, is not keeping pace with the profession's evolving clinical practices and training programs. Therefore, the ACCP BOR has decided to pursue the following course of action:

1. Call for BPS to reconsider its stated intent not to revise the existing framework for pharmacy specialist recognition. A more efficient framework for specialist certification that fully meets societal needs, both now and in the future, should be developed by 2012. This framework should in the near future provide a coherent, quality-assured process for the certification of most clinical pharmacy specialists and subspecialists who are appropriately qualified to seek such recognition. For example, by 2012, a new certification system should be in place (or rapidly evolving) that will provide all

accredited clinical practice PGY2 residency graduates the option to seek certification in their respective clinical specialty or subspecialty. ACCP recognizes the impracticality of expecting this new framework to be fully functional by 2012. Nonetheless, it is reasonable to expect that BPS will produce a cogent plan, together with a timetable for implementation over a 3-year period, by 2012.

2. Reach out to thought leaders in the profession, ACCP PRN leaders, and other clinical pharmacy certification stakeholders, asking them to implore BPS to develop and implement a more efficient and contemporary approach to specialist/subspecialist certification.

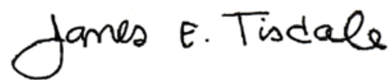
3. Explore options other than BPS to effect clinical pharmacy specialist/subspecialist certification in the future. In doing so, ACCP will closely analyze the report on specialist certification (available at http://bpsweb.org/pdfs/knapp_report2009.pdf) prepared for BPS by Knapp & Associates International and the policies and procedures of other professional certification bodies. Should BPS find itself unwilling or unable to address the needs described above, ACCP is committed to making certain that clinical pharmacy specialists and subspecialists have other options to achieve appropriate recognition in their respective practice areas.

4. Between now and 2012, ACCP will continue to support BPS efforts to increase practitioners' access to specialist certification.

I hope this lengthy communication helps explain why we consider this issue such a quandary for the College. I also hope this letter clarifies for ACCP members some of the College's past, present, and future efforts to support board certification. Above all, we recognize that the purpose of establishing a new, more coherent specialty certification process for the profession is singular: to benefit the patients we serve by ensuring that the pharmacy profession has established a credible, quality-assured, and robust system to recognize specialties and certify specialists, both now and in the future. Without such a system to define and recognize clinical pharmacists with specialized knowledge and skills, patients will not be ensured of receiving the quality of pharmacotherapeutic care they deserve.

As always, I welcome your comments. Please forward them to me by e-mail at accp@accp.com, entering "Tisdale" on the subject line of your message.

Sincerely,



James E. Tisdale, Pharm.D., FCCP, FAPhA, BCPS (AQ Cardiology)
ACCP President

Citation:

[1]CPNP, the College of Psychiatric and Neurologic Pharmacists; HOPA, the Hematology Oncology Pharmacy Association; PPAG, the Pediatric Pharmacy Advocacy Group; SCCM, the Society of Critical Care Medicine; SIDP, the Society of Infectious Disease Pharmacists.