

ASHP Statement on the Role of Pharmacists in Primary Care

Position

ASHP believes that pharmacists have a role in meeting the primary care needs of patients directly and in collaboration with other healthcare providers. Primary 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.¹ Primary care pharmacy practice is accomplished through the provision of direct patient care and medication management services (MMS) for ambulatory patients, development of long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self-management. The primary care pharmacist provides primary care services in a variety of settings, including institutional, private, and community-based clinics. Primary care pharmacists help offset deficits in the primary care workforce caused by a shortage of physicians and other healthcare providers, particularly for underserved populations, by providing MMS in interdisciplinary team-based settings as well as in areas such as telehealth, population health, transitions of care, employer-based services, lifestyle medicine, accountable care organizations, and public health. Primary care pharmacists are often embedded into the primary care practice to provide MMS.

Many states allow pharmacists to partner with physicians via collaborative practice agreements (CPAs) that enable physicians to delegate specific tasks (e.g., initiation, titration, and discontinuation of medications; laboratory monitoring of therapy; medication and disease state monitoring) to a pharmacist. ASHP supports passage of federal and state laws and regulations that authorize pharmacists as providers within collaborative practice and that facilitate reimbursement for services provided by pharmacists.² Further, ASHP advocates that pharmacists be recognized as providers in federal, state, and third-party payment programs. Provider recognition would facilitate direct billing for services provided, similar to billing by physicians, nurse practitioners, clinical nurse specialists, and physician assistants.³ Until that

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recognition is obtained, ASHP encourages healthcare organizations to use a variety of models to ensure the financial sustainability of services provided by primary care pharmacists, such as through indirect funding, incident-to billing, and increased use of the limited direct insurance billing opportunities available. Several states have passed pharmacist provider status laws or reimbursement parity laws allowing for reimbursement for direct patient care pharmacist services by state Medicaid and/or commercial plans.⁴

As pharmacists become core members of the primary care workforce, credentialing and privileging with payers and healthcare organizations will be essential. As credentialed providers, pharmacists are able to both provide patient care services and contribute to the financial sustainability of those services. Privileging protects their employing organizations from legal risk and ensures patients receive care from qualified and competent providers. ASHP recommends the use of credentialing and privileging in a manner consistent with other healthcare professionals to assess a pharmacist's competence to engage in patient care services.⁵ Credentialing and privileging systems already exist for physicians, physician assistants, and nurse practitioners, but are far less common for pharmacists. Integration of pharmacists into existing processes will enable the profession to function collaboratively and in parallel with their colleagues and assist in preparing for pharmacist provider status. There are many opportunities for pharmacists who practice in primary care settings to seek additional credentials beyond a pharmacy degree and licensure, and certain credentials may be required to obtain specific privileges to provide MMS. The variety of state requirements to provide primary care pharmacist services can be a barrier to patient access to those services, thus standardized credentialing is needed.

Primary healthcare

A 2021 National Academies of Science, Engineering and Medicine report defined high-quality primary care as “the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.”⁶ The report stated that high-quality primary care is a

critical component to achieving the quadruple aims of healthcare: enhancing the patient experience, improving population health, reducing costs, and improving the health care team experience.⁶

Primary healthcare is a comprehensive and holistic care approach to health and well-being that is centered on and tailored to the needs of individuals, families, and communities. The World Health Organization (WHO) has developed a three-component definition of primary care:

1. Meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life cycle, prioritizing key healthcare services aimed at individuals/families through primary care and the population through public health functions as the central elements of integrated health services.
2. Systematically addressing the determinants of health (social, economic, environmental, as well as people's characteristics and behaviors) through evidence-informed public policies and actions across all sectors.
3. Empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care-givers to others.⁷

Primary 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.¹ This practice is accomplished through direct patient care and medication management for ambulatory patients, development of long-term relationships, coordination of care, patient advocacy, wellness and health promotion, triage and referral, and patient education and self-management. The primary care pharmacist may practice in institutional, private, and community-based clinics involved in the provision of direct care to diverse patient populations.

Services provided by primary care pharmacists

Primary care pharmacists may help to offset deficits in the primary care workforce, including the physician shortage, by providing MMS in interdisciplinary team-based settings as well as

areas such as telehealth, population health, transitions of care, employer-based services, lifestyle medicine, and public health. Clinical pharmacy services may include:

- Immunizations and travel vaccines.
- Medication therapy management (MTM).
- Collaborative drug therapy management (CDTM).
- Comprehensive medication management (CMM).
- Focused specialty management of chronic diseases (e.g., anticoagulation, diabetes, heart failure).
- Management of complex acute conditions or exacerbation of chronic conditions (e.g., urinary tract infection, chronic obstructive pulmonary disease, asthma).
- Provision of personalized medicine (e.g. pharmacogenomics)
- Patient counseling, education, and training.

Examples of practice settings in which pharmacists provide primary care services include:

- Accountable care organizations (ACOs)
- Community-based or free clinic
- Community pharmacy
- Federally Qualified Health Center (FQHC)
- Hospital-based outpatient clinic
- Indian Health Service clinic
- Managed care integrated system
- Outpatient clinic associated with academic medical center
- Patient-centered medical home (PCMH)
- Private practice physician clinic
- Rural health clinic (RHC)
- Self-insured employee clinic
- Veterans Affairs (VA) medical center

MMS. Primary care pharmacists are often embedded into the primary care practice to provide MMS. MMS has been defined by the Joint Commission of Pharmacy Practitioners (JCPP) as “a spectrum of patient-centered, pharmacist-provided, collaborative services that focus on medication appropriateness, effectiveness, safety, and adherence with the goal of improving health outcomes.”⁸ For the purposes of this statement, MMS “encompasses a variety of terms, such as medication therapy management (MTM), comprehensive medication management (CMM), and collaborative medication management,” as in the JCPP definition.³ The pharmacist may be an employee of the practice, a department of pharmacy, or a health professions school or college, and may dedicate a part- or full-time effort to providing clinical pharmacy services. Care may be provided face-to-face or via telehealth visits to manage medications for patients with chronic illnesses such as hypertension, diabetes, chronic heart failure, asthma, chronic obstructive pulmonary disease, anticoagulation, osteoporosis, and many others. Primary care pharmacists often provide patient education about lifestyle choices or conduct annual wellness visits (AWVs) for patients with Medicare. Many states allow pharmacists to collaborate with physicians through CPAs that enable physicians to delegate specific tasks such as medication initiation, titration, or discontinuation; laboratory monitoring of drug therapy; and referral for medication and disease state management to the pharmacist.

Transitions of care services. The term *transitions of care* refers to the movement of patients between healthcare practitioners, settings, and home as their condition and care needs change.⁹ During transitions, medication regimens are frequently changed and may include medication discontinuation, dosage changes, and new prescriptions that can be confusing for patients and caregivers to manage. Poor-quality transitions contribute to medication errors, hospital readmissions, and increased healthcare costs.⁹ Pharmacists in the primary care setting can support patients and caregivers as they adjust to new diagnoses, care plans, and medications.

Established Transitional Care Management (TCM) Current Procedural Terminology (CPT) codes allow for billing of transitions of care services, providing a mechanism for reimbursement.^{10,11} There are three required elements to bill for TCM services:

1. Interactive communication (e.g., phone, text, email) must occur with the patient or caregiver within 2 days of discharge by a licensed clinical staff member, which can be the primary care pharmacist.
2. Medical decision making of moderate to high complexity occurs during the service period.
3. The patient has a face-to-face or telehealth visit within 7-14 days of discharge.

Services during TCM visits often include reviewing medical records, reconciling medications, coordinating future visits, and providing patient education. Pharmacists may be involved with all components of TCM, but the services can only be billed by a physician or a qualified nonphysician provider such as a nurse practitioner or physician assistant according to current Centers for Medicare & Medicaid Services (CMS) rules. Inclusion of pharmacists in the definition of a nonphysician provider would allow pharmacists to perform these services, among others, and reduce the burden on primary care providers.

ASHP and the American Pharmacists Association (APhA) collaborated to develop the Medication Management in Care Transitions (MMCT) Best Practices that spotlight transitions of care models in pharmacy practice and provide resources for pharmacy leaders.¹² Successful programs improved patient satisfaction scores and decreased readmission rates and medication discrepancies.¹² A descriptive study that evaluated the impact of care transitions intervention on clinical, organizational, and financial outcomes found that adding a pharmacist to the care transitions team decreased hospital readmissions compared to usual care (9 vs. 26%) and prevented 103 admissions per year, translating to an annual savings of over \$1 million.¹³

Services offered through employer-based health plans. Employers may offer chronic disease management or healthy lifestyle programs to employees as part of their human resources benefits package. Pharmacists are essential team members who can provide chronic disease medication management to employees enrolled in self-insured health plans. The Asheville Project demonstrated that pharmacists who cared for City of Asheville employees with diabetes improved patient satisfaction with their healthcare, decreased healthcare costs, and increased the number of patients who achieved hemoglobin A1c, lipid, and blood pressure

goals.¹⁴ An evaluation of a national employer-based program offered by 10 organizations in 70 different communities indicated that pharmacists improved other diabetes-related population health metrics, including monofilament examinations, annual dilated eye examinations, foot self-exams, glucose self-monitoring, weekly exercise, and annual influenza vaccines.¹⁵

Population health services. A shift to population health strategies in primary care has been driven by increasing healthcare costs, emphasis on fee-for-service over value-based care, and lack of widespread prevention initiatives. Primary care pharmacists who dedicate their time to population health management focus on improving the quality of care for specific patient populations. Specific population health metrics that warrant improvement are identified by leaders within the PCMH, the ACO, through community health assessments, or by payers such as Medicare, Medicaid, and private insurers. Demonstration in improved quality metrics may be linked with pay-for-performance payment bonuses, or shared savings incentives. For example, if a metric of importance to the practice is to improve the quality of care for patients with diabetes, primary care pharmacists can provide MMS for high-risk patients to improve attainment of hemoglobin A1c goals.¹⁶

Public health services. Expertise in the domain of public health is increasingly important for the primary care pharmacist due to the impact of public care challenges such as the opioid epidemic, unintended pregnancy with resultant negative maternal fetal outcomes, tobacco abuse, and the COVID-19 pandemic. The Opioid and Naloxone Education (ONE) program has demonstrated the ability of pharmacists to ensure safe opioid use, and prevent opioid misuse and abuse, through implementing naloxone prescribing while utilizing the pharmacist's patient care process.¹⁷ A growing number of states allow pharmacists to prescribe hormonal contraception as a strategy to increase access to care and decrease negative maternal outcomes.¹⁸ Oregon pharmacists prescribing hormonal contraception prevented 51 unintended pregnancies and saved Oregon Medicaid over \$1.6 million.¹⁹ As of February 2021, six states (Idaho, Colorado, Indiana, West Virginia, Vermont, North Dakota, and New Mexico) have authorized pharmacists to prescribe all FDA-approved tobacco cessation products, including varenicline, to combat the negative impact of smoking on public health; Oregon and North Dakota are currently developing regulations to implement authorizing legislation.²⁰

Pharmacists in primary care settings are also well-positioned to identify immunization needs of patients, provide education to promote vaccine confidence, and administer vaccines. During the COVID-19 pandemic, the U.S. Department of Health and Human Resources authorized immunizing pharmacists to administer childhood vaccines²¹ and COVID-19 vaccines²² as part of the Public Readiness and Emergency Preparedness (PREP) Act.

Telehealth. The Health Resources and Services Administration (HRSA) defines telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, health administration and public health.”²³ Telehealth has been used for a variety of patient populations, including veterans, rural patients, and patients with psychiatric conditions. The COVID-19 pandemic accelerated the delivery of primary care services by telehealth. The federal government established temporary measures in 2020 to increase access to telehealth during the pandemic through the Coronavirus Preparedness and Response Supplemental Appropriations Act. In addition, CMS relaxed rules for supervision of auxiliary personnel to allow physicians to provide “virtual” supervision in order to promote social distancing and protect frontline healthcare workers.

Telehealth visits may be billed by physicians and nonphysician providers and are paid at the same fee-for-service rate as in-person visits for Medicare recipients. Pharmacists may be able to bill using certain approved telephone codes. Reimbursement may vary for Medicaid and private insurance.

Special practice settings and patient populations

Rural health. Rural areas make up approximately 97% of the land area in the U.S., yet account for just a little over 19% of the total U.S. population.²⁴ People living in rural areas are often underserved and experience significant health disparities that can vary between geographical regions and across socioeconomic spectra. Many of the health-related challenges faced by rural America are amplified by the lack of adequate services, particularly primary care providers and medical specialists. Approximately 90% of Americans live within 5 miles of a

community pharmacy, creating additional opportunities for pharmacists to partner with primary care providers and provide clinical pharmacy services for rural, underserved patients.²⁵

The expansion of pharmacist-delivered services in rural settings is an important strategy to target health disparities that are more common causes of mortality for people who live in rural communities than those living in urban areas. Chronic disease state management, MMS, health screenings, tobacco cessation management and prescribing, medication-assisted treatment of opioid use disorders, and lifestyle coaching through diabetes prevention programs are examples of services that address these common health disparities and can be led by pharmacists or enhanced through interprofessional collaboration with pharmacists as allowed under state-specific pharmacy practice acts. Unique training programs focused on rural pharmacy health exist at several colleges of pharmacy that focus on preparing pharmacists for leadership roles in small and rural communities.²⁶

Many health systems that serve rural America receive reimbursement through all-inclusive payment models by Medicare and many state bill Medicaid plans. However, the lack of pharmacist recognition as an independent billable provider by the majority of payers, including Medicare, can challenge the financial feasibility of advanced pharmacist services within these settings.²⁷ Pharmacists can assist or serve a key role in grant-funded projects and programs and, in the case of government-funded grants, can lead to perpetual funding to rural health providers such as FQHCs, RHCs, and the Indian Health Service as a mechanism to defray pharmacist costs. Examples of sustainable practice models that incorporate pharmacist-delivered care in rural areas include the following:

1. Synchronous or co-visits between a pharmacist and a primary care practitioner who is recognized as an independent billable provider.
2. Visits with a pharmacist independent of other health professionals.
3. Pharmacist involvement in comprehensive care services as part of the PCMH or ambulatory primary care clinic care team.
4. Population health services that focus on quality improvement and can increase reimbursement to the health system or collaborating primary care provider through individual visits with the pharmacist face-to-face or via telehealth, including remote

physiologic monitoring (examples of quality improvement measures include blood pressure control, warfarin monitoring, glycemic control, rates of influenza immunizations, and adherence to medication refills [e.g., statin therapy, antiplatelet medications, oral glucose-lowering medications]).

5. Pharmacists involved in accredited Diabetes Self-Management Training (DSMT) programs.

Partnerships between primary care providers and local community pharmacies, critical access pharmacies, or academic institutions can increase access to essential services such as immunization delivery, point-of-care testing, and disease state education and management to people living in rural areas with limited access to primary care providers.²⁸⁻³⁰

FQHCs. FQHCs are considered safety net health providers of outpatient clinical services that receive funding from the HRSA Health Center Program to provide care to individuals in underserved areas.³¹ The primary purpose of FQHCs is the provision of primary care services in underserved urban and rural communities. FQHCs are typically located in community health centers but are also found in public housing primary care centers, outpatient health programs operated by a tribe or urban Indian organization, migrant health centers, and healthcare for the homeless centers. Among the requirements of FQHCs are the provision of a sliding fee scale system for uninsured patients with incomes below 200% of the federal poverty guidelines, provision of comprehensive healthcare services (which include medical, pharmacy, dental, and behavioral health), an ongoing quality assurance program, and a governing board of directors.³²

FQHCs often need to meet the challenges of geographic, social, economic, linguistic, and cultural patient barriers. Primary care pharmacists working in clinical roles within an FQHC can have a tremendous impact on the care of this underserved patient population. Socioeconomic and cultural/language barriers present unique challenges to medication therapy that pharmacists are well suited to help overcome. Chronic diseases are common, noting a high prevalence of hypertension, diabetes and tobacco use. The Uniform Data System requires FQHCs to report on quality of care measures, therefore providing an opportunity for pharmacists to assist in the design and implementation of clinical services aimed at meeting quality benchmarks, as well as participate in the reporting process.

FQHCs differ from traditional primary care practices in the way that payment is issued for primary care encounters. An encounter payment is issued under the FQHC Prospective Payment System (PPS) from CMS that includes medical services, supplies, and overall service coordination provided to patients. The specific payment amount is unique to each FQHC and is determined based on reasonable costs and cost reporting. Because the PPS is provided through CMS, only practitioners who are recognized as healthcare providers by Medicare are eligible to bill directly for services. Because pharmacists are not recognized as healthcare providers federally, any eligible services provided by a pharmacist may not be billed directly but must rather be billed by an eligible healthcare provider. Despite the limited opportunities for pharmacists to promote sustainability through direct revenue, such as Medicare AWVs, there are many primary care services provided by pharmacists in FQHCs that benefit the practice. FQHCs that participate in the 340B program, which provides medication cost savings to uninsured and underinsured patients as well as savings to the pharmacy, commonly leverage the savings to support clinical pharmacy services (e.g., hiring or salary support of a clinical pharmacist). Examples of services provided by pharmacists in FQHCs include:

- MTM
- 340B Program
- Specialty Pharmacy Services
- Spirometry
- Chronic Care Management (CCM) and Principal Care Management (PCM)
- Diabetes Self-Management Training (DSMT)
- Value-Based Care
- Quality Improvement/PCMH
- CDTM/Contract Agreements/Consult Agreements
- Population Health
- Medicare AWVs
- TCM

Additional detailed information can be found in the ASHP Resource Center document, “Opportunities for Sustainable Pharmacy Services in Federally Qualified Health Centers.”³³

Billing and reimbursement for primary care pharmacy services

The National Academy of Sciences recommends that payers, including Medicaid, Medicare, commercial insurers, and self-insured employers, should shift payments toward a hybrid model that includes fee-for-service and capitated payments, and that these models should pay prospectively for interprofessional, integrated, team-based care.⁶ Financial sustainability for services provided by primary care pharmacists may be achieved using a variety of models. Due to lack of federal provider status for pharmacists and subsequent inability to directly bill Medicare as primary care providers, organizations and practices have become creative in maintaining financial sustainability of primary care pharmacist services. Some settings utilize indirect funding, while others take advantage of some of the limited direct insurance billing opportunities to fund pharmacists in primary care settings. Direct billing opportunities will vary based on the setting, hospital-based versus physician-based practices, as well as state-specific laws and regulations. Medicare, Medicaid, and commercial health plans may reimburse pharmacists for certain services, while some will require direct contracting with the health plan. Several states have passed pharmacist state provider status laws and/or reimbursement parity laws allowing for reimbursement for direct patient care pharmacist services by state Medicaid and/or commercial plans.⁴ Some examples of direct and indirect billing methods are listed in Table 1.

Table 1. Examples of direct and indirect funding methods.³⁴

Indirect billing	Direct billing
Funding by Colleges of Pharmacy/Academic Health Centers: shared pharmacy practice faculty in primary care settings Affordable Care Organizations/Managed Care Insurance Plans <ul style="list-style-type: none"> • Quality improvement/achieving quality metrics • Reducing medication adverse events/improving disease management 340B Drug Program Covered Entities: Reinvestment of 340B drug cost savings in salary for clinical pharmacists ³⁵	Medicare Part B/D: <ul style="list-style-type: none"> • Annual Wellness Visits • Chronic Care Management • Facility Fee Billing (hospital-based clinics)³⁶ • Incident-to (physician-based clinics)³⁷ • MTM contract with Medicare Part D plans³⁸ • Transitional Care Management Medicaid or Commercial Health Plans: <ul style="list-style-type: none"> • State law dependent^{39,40}

Credentialing and privileging

As pharmacists look to fill gaps in the primary care workforce and create financially sustainable practices, credentialing and privileging with payers and healthcare organizations are essential. Credentialing and privileging are two separate processes. Credentialing is the process by which an individual's credentials (i.e., academic, license, certifications) are verified to reflect that they have the appropriate training to practice as a pharmacist. Privileging evaluates and authorizes providers to deliver care within a requested scope of practice. For example, if a pharmacist is practicing in a specialty clinic such as hematology/oncology, they would have a different scope than when practicing in a primary care setting. The privileging process ensures individuals have the training and competency to provide the requested services in a particular specialty. Often this verification is obtained through a peer evaluation process, whereby colleagues provide feedback on the provider's clinical knowledge, skills, and professional performance.

With the expanding roles of pharmacists, growth in specialization, and the increased complexity of healthcare, the credentialing and privileging process is more important than ever. Credentialing is required by payers in order for providers to bill for services. As credentialed providers, pharmacists are able to both provide patient care services and contribute to the financial sustainability of the service. Privileging protects the organization from legal risk and ensures patients receive care from qualified and competent providers. These systems already exist for pharmacists, physician, physician assistant, and nurse practitioner colleagues; integration of pharmacists into existing processes will enable the profession to function in parallel and collaboratively with our colleagues and assist in preparing for provider status.

Credentials beyond pharmacy degree and state licensure

There are multiple opportunities for pharmacists who practice in primary care settings to seek additional credentials beyond the pharmacy degree and licensure, and certain credentials may be required to obtain specific privileges to provide MMS. For example, pharmacists who prescribe hormonal contraception or who serve as immunizing pharmacists must complete training and/or certificate programs to be eligible to provide those services in their state. Certain requirements must also be met in order to enter into CPAs and vary by state. Pharmacists who practice under a CPA in New Mexico, California, Montana, and North Carolina are recognized as Pharmacist Clinician (NM), Advanced Practice Pharmacist (CA), and Clinical Pharmacist Practitioner (NC and MT). The wide variety of state requirements to provide primary care pharmacy services serves as a barrier for patient access to services, and advocacy to standardize credentialing is needed.

Employers may require that primary care pharmacists complete a postgraduate year 1 (PGY1) and/or a PGY2 residency training program. They may also require board certification through the Board of Pharmacy Specialties or completion of an interprofessional certificate, such as the Certified Asthma Educator (AE-C), Certified Diabetes Care and Education Specialist (CDCES, formerly Certified Diabetes Educator or CDE), or Certified Anticoagulation Care Provider (CACP), among others. A listing of board certification opportunities along with eligibility criteria for examination are listed in the Appendix. All board certification programs

listed incur an examination fee, and pharmacists must achieve a passing score on the examination and meet ongoing requirements for renewal. Benefits of board certification include greater marketability, enhanced confidence, improved competence, increased responsibility, and a competitive edge in job placement and advancement.⁴¹ The Council on Credentialing in Pharmacy has established guiding principles for post-licensure credentialing of pharmacists.⁴²

Conclusion

There are many avenues in which pharmacists can become involved in primary care practice. Identifying the ideal practice model and service offering will involve collaboration with other healthcare providers as well as identifying a patient population and target outcome. Achievement of federal provider status will allow pharmacists the ability to bill Medicare and create sustainable services and financial stability, as has been demonstrated in states with active provider status laws. As pharmacists become more involved in primary care practice, healthcare will move closer towards the goal of optimal, safe, and effective use of medications for all people all of the time.

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Additional information

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Appendix. Board Certification Opportunities for Primary Care Pharmacists

Credential	Certification Body	Eligibility Criteria for Examination
<i>Ambulatory Care</i>		
Board Certified Ambulatory Care Pharmacist (BCACP)	Board of Pharmacy Specialties https://www.bpsweb.org/bps-specialties/ambulatory-care/	<ul style="list-style-type: none"> • Graduation from an ACPE accredited pharmacy program • Current license to practice • Demonstration of ambulatory care practice experience
<i>Anticoagulation</i>		
Certified Anticoagulation Care Provider (CACP)	National Certification Board for Anticoagulation Care Providers www.ncbap.org	<ul style="list-style-type: none"> • Must hold professional license for two years • Registered nurse, nurse practitioner, registered pharmacist, physician, or physician assistant • 750 hours of active antithrombotic management within the 18 months prior to taking the examination
<i>Asthma</i>		
Certified Asthma Educator (AE-C)	National Asthma Educator Certification Board https://naecb.com/	<ul style="list-style-type: none"> • Licensed healthcare professionals such as pharmacists, physicians, physician assistants, nurses, respiratory therapists, pulmonary function technologists, social workers, health educators, physical therapists, and occupational therapists • Individuals providing direct patient asthma education, counseling or coordinating services with a minimum of 1000 hours experience in these activities
<i>Diabetes</i>		
Board Certified Advanced Diabetes Management (BC-ADM)	Association of Diabetes Care and Education Specialists https://www.diabeteseducator.org/education/certification/bc_adm	<ul style="list-style-type: none"> • Registered nurse, nurse practitioner, clinical nurse specialists, registered dietician, pharmacist, physician assistant, physician • 500 clinical practice hours within 48 months of taking the examination

Certified Diabetes Care and Education Specialist (CDCES)*	Certification Board for Diabetes Care and Education https://www.cbdce.org/	<ul style="list-style-type: none"> • Qualifying healthcare professional: registered nurse, nurse practitioner, registered dietician, pharmacist, physician assistant, physician, and others • 2 years of prior professional experience • A minimum of 1000 hours providing diabetes care and education in the previous 4 years with a minimum of 400 hours in the previous year • A minimum of 15 hours of approved continuing education focused on diabetes in the previous 2 years
<i>Geriatrics</i>		
Board Certified Geriatric Pharmacist (BCGP)	Board of Pharmacy Specialties https://www.bpsweb.org/bps-specialties/geriatric-pharmacy/	<ul style="list-style-type: none"> • Graduation from an ACPE accredited pharmacy program • Current license to practice • Demonstration of geriatric practice experience
<i>HIV</i>		
HIV Pharmacist (AAHIVP)	American Academy of HIV Medicine https://aahivm.org/hiv-pharmacist/	<ul style="list-style-type: none"> • Pharmacist licensure • Documentation of direct HIV care for 25 patients living with HIV within the preceding 36 months • Participate in the Academy's Clinical Consult Form • Complete a minimum of 45 credits or activity hours of HIV and/or HCV-related continuing education within the preceding 36 months
<i>Lipids</i>		
Clinical Lipid Specialist (CLS)	Accreditation Council for Clinical Lipidology https://www.lipidspecialist.org/certchoose/cls/	<ul style="list-style-type: none"> • Completed a minimum of 10 continuing education credit hours in clinical lipidology in the previous 2 years • Physicians, nurses, nurse practitioners, physician assistants, pharmacists, registered dietitians/nutritionists, clinical exercise physiologists/specialists

		<ul style="list-style-type: none"> • 2000 hours of demonstrated clinical experience in the management of patients with lipid or other related disorders • Additional training requirements
<i>Medication Therapy Management</i>		
Board Certified Medication Therapy Management Specialist (BCMTMS)	The National Board of Medication Therapy Management (NBMTM) https://www.nbmtm.org/bcmtms/	<ul style="list-style-type: none"> • Pharmacy degree • Pharmacy license • 2 years of experience in MTM experience or NBMTM training
<i>Psychiatry</i>		
Board Certified Psychiatric Pharmacist (BCPP)	Board of Pharmacy Specialties https://www.bpsweb.org/bps-specialties/psychiatric-pharmacy/	<ul style="list-style-type: none"> • Graduation from an ACPE accredited pharmacy program • Current license to practice • Defined practice experiences or PGY2 Psychiatric Pharmacy Residency

*previously the Certified Diabetes Educator (CDE)

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