Objectives

• Identify the need for medication therapy management (MTM)
• Describe how MTM benefits patients and providers
• Explain the scope, process and components of MTM
• Explain how to collaborate with MTM providers
• Evaluate how current opportunities coincide with your practice as a primary care provider.

Outline

1. What is MTM?
2. What is the impact of MTM?
3. How does MTM work?
4. How can providers get involved?

Background

• Medication therapy management (MTM) is medical care aimed at optimizing drug therapy and improving therapeutic outcomes for patients (not just counseling)
• Medicare Modernization Act of 2003
• Sponsors of prescription drug plans (PDP) and Medicare advantage plans (MAPD) are mandated to offer MTM
• Basic eligibility and components are determined by CMS

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Medication Therapy Management: Opportunities in an Underutilized Service

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In collaboration with:
Los Angeles County Department of Public Health,
Chronic Disease and Injury Prevention Program
Need

- 80% of Americans are on at least 1 chronic medication¹
- 1/3 don’t fill their 1st prescription²
- Primary care provider shortage³
  - Physician shortage of 20,400 by 2020
  - PA-Cs and NPs reduce this burden
- Costs of adverse drug reactions ($3.5 billion)²
- Increased emphasis on quality measures

3. Health resources and services administration. Projecting the Supply and Demand for Primary Care Practitioners Through 2020. 2013.

Goals of MTM

- Facilitate collaboration
- Promote safe and effective medication use
- Shift utilization of healthcare resources
- Achieve optimal patient and quality outcomes
Outcomes

- Return on investment
  - Health plan saves $4-12 per $1 spent
- Quality measures
  - Double the patients reached A1c <9% than control
  - Improvements in A1c, cholesterol, and blood pressure
- Satisfaction
  - Physician - 4.8 out of 5
  - Patient - 4.8-4.9 out of 5 (anticoagulation, comprehensive care, discharge)

Outcomes

- Clinical outcomes
  - 50-66% reduction in readmissions\(^1,2\)
  - 41% reduction in ED visits\(^3\)
  - 57% more hypertensive patients at goal\(^1\)
  - Despite results, poor utilization (8%)\(^4\)

3. Siegel D. In uncontrolled hypertension, a pharmacist-prescribing intervention reduced blood pressure at 6 months. 2015

How Does MTM Work?

MTM Referral

- Health plan
  - Medicare Part D criteria
- Primary care provider
  - Integrated, team-based care
  - External, out patient pharmacy
- Pharmacist
  - Academia

MTM Process

- Interview
- Measurements
- Assessment/Plan
- Documentation
- Communicating with PCP and other providers

Interview

- Subjective and objective data
- Medication reconciliation
  - Comprehensive medication review
- Lifestyle
- Immunization history
- Allergies
- Labs (when available)
Measurements

- Physical Measurements
- Serum point-of-care testing
- On the horizon
  - Eye, ear, lung, and liver assessment
  - Pharmacogenomic testing

Assessment

- Subjective
- Risk factors
  - ASCVD
  - Metabolic syndrome
  - Bleeding
  - VTE
  - Falls (Beers list)
- Medication safety/efficacy
- Patient barriers

Plan

- Patient education
  - Drug
  - Disease
  - Behavior (Motivational Interviewing)
  - Referral
- Provider consultation
  - Sharing of information
  - Team-based care
- Therapy adjustments
  - Recommendations made to prescriber
  - Can be done under protocol
Motivational Interviewing
• A tool for directing positive behavior
• Utilizes open-ended questions, affirmations, reflections and summaries
• Provider establishes discrepancies between goals and behavior
• Stage of change
  • Transtheoretical Model
  • Precontemplation, contemplation, determination, action, relapse, maintenance

Documentation and Communication
• Medicare standardized documents
  • Cover letter
  • Personal medication list
  • Medication action plan
• SOAP/Chart note
  • For interviewer’s record
  • Given to PCP and other prescribers
  • Logistically difficult due to independent EMRs

Settings and variations
• Community pharmacy, AKA retail or outpatient
• Ambulatory care
  • Medical office
  • Patient-centered medical home
  • Hospital
  • Inpatient

Community
• Advantages
  • Medication record from multiple providers
  • Pickup rate can help assess adherence
  • Out-of-pocket cost
  • Regular interaction with patient
  • Locations and hours
• Limitations
  • Access to labs and EMR
  • Access to PCP and other providers

Ambulatory
• Advantages
  • Access to labs and provider notes
  • Work closely with providers
  • Easier to establish a collaborative practice agreement
    • Comprehensive medication management
• Limitations
  • Pickup rate not evident
  • Records from outside providers
  • Formulary and out-of-pocket costs

Inpatient
• Advantages
  • Adherence while admitted is not an issue
  • Access to providers and EMR
• Limitations
  • Transition-of-care is problematic
  • Outpatient adherence
  • Dispensing records from outside providers
  • Formulary and out-of-pocket costs
JD, a 67 year old white female, presents to the community pharmacy for her annual comprehensive medication review and to fill a new prescription for UTI.

**Medication Profile**

- **Metformin 1000mg twice daily #60 (PCP)**
- **Albuterol HFA 90mcg 1-2p q4-6h prn #1 (PCP)**
- **Carvedilol 25mg twice daily #60 (Cardiologist)**
- **Carvedilol 12.5mg twice daily #60 (Cardiologist; discontinued)**
- **Lisinopril 10mg daily #30 (Cardiologist)**
- **Gabapentin 600mg three times daily #90 (PCP)**
- **Influenza Vaccine (High Dose) (per protocol by Pharmacy)**

**New Rx:**

- **Ciprofloxacin 250mg twice daily #14**

**Pharmacy Dispensing Record**

- **Metformin 1000mg** (15 days ago)
- **Albuterol HFA 90mcg** (7 days ago and 40 days ago)
- **Carvedilol 25mg** (15 days ago)
- **Carvedilol 12.5mg** (45 days ago)
- **Lisinopril 10mg** (15 days ago)
- **Gabapentin 600mg** (15 days ago)
- **Influenza Vaccine HD** (per protocol by Pharmacy)

**Data Discrepancy**

- Labs are needed to assess efficacy and safety for many medications
- Some clinical information can be obtained from the patient
- Pharmacy rarely has access to EMR
- Need to rely on communication
- May perform point-of-care measurements

- Currently complains of fatigue, more frequent wheezing, urinary discomfort (went to urgent care)

**Per Patient:**

- Diagnosed with DM (type 2), HTN, CHF, asthma, UTI
- She does not recall A1c or other labs
- Her PCP told her that her kidneys are “doing well”
- When asked if she has ever been on a “statin,” she replied “I don’t know what that is.”
- Immunizations are up to date

**Per Pharmacist:**

- Height 67 inches
- Weight 162.8 lbs
- BMI 25.5kg/m2
- BP 132/76 mmHg
- Ciprofloxacin dose is a red flag, may indicate reduced kidney function

**Patient Case (With Collaboration)**

- Labs from PCP (Dated 9 months ago)
  - A1c 6.7%
  - BP 132/76
  - HR 84
  - EF 30%
  - TC 130
  - HDL 40
  - LDL 157
  - Na 138
  - K 4.7
- **Ca 9.1**
- **PT 10.5**
- **CRP 28**
- **SO 1.0**
- **BUN 17**
- **eGFR >60**
- **ALK 4.1**
- **AST 21**
- **ALT 25**

- Childhood series completed
- Tdap, Shingles, PCV-13 all given 1 year ago
- PPSV-23 given 6 years ago

**Patient Case (Without Collaboration)**

- Labs from Urgent Care (1 day old)
  - SCr 1.6mg/dL
  - CrCl 33.2mL/min
Patient Case (With Collaboration)

Subjective/objective
- JD, 67F with DM2, HTN, CHF, asthma, UTI
- Chief complaint: increased rescue inhaler use, recent fatigue and urinary discomfort
- Crcl recently decreased from >60mL/min to 33.2mL/min
- Compliant with medication regimen (per dispensing record)
- Beta blocker dose increased 1.5 months ago
- Social, diet and exercise appropriate per ADA guidelines

Assessment
- Increase in carvedilol (non-selective beta blocker) associated with increased need of rescue inhaler
- Metoprolol succinate is preferred beta-blocker (EF <40%, comorbid asthma). Target dose is 200mg daily (ACCF/AHA)
- Metformin is contraindicated for SCr ≥1.4mg/dL in women
- Gabapentin may be contributing to fatigue and should be reduced for due to kidney function
- Patient indicated for high-intensity statin therapy (ACC/AHA; diabetes and 10-year ASCVD risk 19.8%)
- Lisinopril not at target dose of 20-40mg daily (ACCF/AHA)
- PPSV-23 due (ADA; ACIP)

Recommendation
- PCP
  - Discontinue metformin, consider starting alternative therapy
  - Reduce gabapentin frequency to twice daily
  - Initiate atorvastatin 40mg daily
- Cardiologist
  - Change carvedilol to metoprolol succinate (target 200mg daily)
  - Increase lisinopril to target dose of 20-40mg daily
- PCP or Pharmacist
  - Administer PPSV-23

Getinvolved
- Facilitate the process
- Share relevant information
- Consider recommendations
- Urge patients to participate (it’s free)
- Screen for and inform eligible patients
  - How many diagnoses?
  - How many medications?
  - What is the annual drug cost?
Getting Involved

- Refer to participating providers
- CMS did not include “any willing pharmacy”
- Part D plan sponsor- usually telephonic
- Community pharmacy utilizing 3rd party MTM referral platforms
- Community pharmacy that accepts cash-paying patients
- Face-to-face perform better than telephonic in studies but no direct comparisons exist
- Start pharmacy services

Pharmacy Familiarity

- Some patients will benefit from paying cash
- Not all pharmacies accept cash patients
- Best practice: form relationships with a pharmacist near you
- Ask the pharmacy:
  - Do you perform MTM?
  - Can you bill for it?
  - What is your cash price?
  - Provide contact info

Beyond Medicare

- Health plan determines eligibility¹
  - Annual cost of medications ($3507)
  - Number of chronic conditions (3 or more)
  - Number of medications (8 or more)
  - These criteria overlook many variables
- Provider offices with pharmacy services
  - More ways to bill
  - Control over eligibility criteria

Examples of other inclusion criteria

- Undergoing transition of care
- Receiving care from multiple providers
- High risk medication use (5 or more)
- Chronic conditions
- Lab values are out of normal range, which may be caused by or alleviated by medication therapy
- History of nonadherence
- Limited health literacy
- Recently experienced a medication related adverse event
- Medications with narrow therapeutic index

¹. CMS 2015 Medicare Part D Medication Therapy Management (MTM) Programs. 2015.

Beyond Medicare

Collaborative practice agreement

- “licensed provider...refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.” -CDC
- Can be performed in any setting in California
- Lead to healthcare savings, improved patient health, and increased preventative care when used effectively

Opportunities for MTM outcomes research

- Lifestyle management for the general population
- Preventing pre-diabetes progression
- Smoking cessation
- Vitamin, herbal, and nutritional supplement
In Summary

MTM providers:
- Work with PCPs and patients
- Assess patient concerns about medications
- Utilize evidence based practice for recommendations
- Prescribers make the final decision on medications

References

- Siegel D. In uncontrolled hypertension, a pharmacist-prescribing intervention reduced blood pressure at 6 months. Am Intern Med. 2015 Nov 17;163(10):JC7.

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