Medication Therapy Management in Community Pharmacy Practice

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Community pharmacists are often the first point of contact for patients with health-related and medication questions. The *2007 Wilson Rx Pharmacy Customer Satisfaction Survey* reports that the average pharmacy customer visits their pharmacy an average of two to three times per month, which is greater than ten times the number of times they visit their primary care physician and greater than 15 times more often than they visit a specialist physician in a year. Community pharmacists are faced with the challenge of identifying and resolving medication-related problems for prescription, nonprescription, herbal, and dietary supplements on a daily basis. In an often fast-paced, busy environment such as a community pharmacy, it is critical for pharmacists to be afforded face-to-face, uninterrupted, quality time with their patients. However, broad scale reimbursement mechanisms for such services were lacking until the establishment of The Medicare Modernization Act of 2003. Effective January 1 2006, this act established a prescription drug benefit for 25 million Medicare beneficiaries. In addition, it afforded pharmacists a platform for reimbursement for the identification and resolution of medication-related problems, entitled **Medication Therapy Management** (**MTM**).[1]

Components of Medication Therapy Management

The Centers of Medicare & Medicaid Services requires Medication Therapy Management as a component of all Medicare Part D prescription drug benefit plans. The goals of MTM services are to improve collaboration among pharmacists, physicians, and other healthcare professionals; enhance communication between patients and their healthcare team; and optimize medication use for improved medication outcomes.[2] Integral to the provision of MTM services is that they are distinct from the medication dispensing process. Therefore, the services provided are patient-centered as opposed to a prescription-focused approach.[3] Though the look and feel of MTM services may vary in the menu of services offered within the pharmaceutical care model, the framework of delivery is consistent and reproducible. In 2004, a joint initiative by The American Pharmacists Association and the National Association of Chain Drug Stores Foundation established a service model document supported by many pharmacy organizations across the spectrum of pharmacy practice. This document, entitled Medication Therapy Management in Pharmacy Practice: Core Elements of an MTM Service Model, updated in 2008, defines the five core elements of an MTM practice.[2] (Table 1)

The hallmark of an MTM service is the **Comprehensive Medication Review** (**CMR**). A CMR is "a review of the beneficiary's medications, including prescription, over-the-counter medications, herbal therapies and dietary supplements, that is intended to aid in assessing medication therapy and optimizing patient outcomes."[4] In short, just as a patient is recommended to see their primary care physician each year for a complete physical, they are also encouraged to see their pharmacist each year for a complete "medication check-up". Once the community pharmacist gathers the medication-related information from the CMR, he/she assesses, identifies, and prioritizes medication-related problems. (Table 2)

Once the medication-related problems have been prioritized, a plan is developed for the resolution of each problem identified. This plan is documented on the patient-centered **Medication-related action plan** (**MAP**) which is created by the pharmacist in conjunction with their patient. The MAP is a list of "to-do's" for the patient to use with their pharmacist, primary care physician, physician specialists, and other healthcare providers to ensure they are working toward their specific health goals. In addition to the MAP, the community pharmacist also creates a **Personal Medication Record** (**PMR**) which is a list of all the patient's medications, both prescription and nonprescription. The MAP and PMR are fluid documents and must be updated regularly with any changes in health status and medication therapy. After the community pharmacist completes a comprehensive medication

Table 1. Core Elements of Medication Therapy Management

Medication Therapy Review (MTR) , also referred to as Comprehensive Medication Review (CMR)
Personal Medication Record (PMR)
Medication-related Action Plan (MAP)
Intervention and/or referral
Documentation and follow-up

Table 2. Possible Medication-related Problems

Medication without an indication
Indication without a medication
Adverse Drugs Effects
Wrong Medication
Wrong Dose
Adherence to therapy
Drug-drug, drug-food, drug-herbal interactions

review, a copy of the medication action plan and the personal medication record are given to the patient, and copies faxed to the primary care physician. These documents are designed to be shared and utilized within all facets of the patient's "medical home." If the community pharmacist identifies medication-related problems that require intervention, such as a potentially harmful drug-drug interaction, the prescriber is immediately contacted. In addition, if referral to another healthcare provider is warranted, such as a dietician for a patient with type 2 diabetes mellitus, the community pharmacist assists the patient with this referral to ensure continuity of care. The last step of the MTM service is documentation and billing. The community pharmacist uses the SOAP note format along with the supporting documents of the medication action plan and personal medication record. The patient's insurance dictates the method in which the community pharmacist bills for their service. In October 2007, three Category I CPT codes were established for MTM services provided by a pharmacist for face-to-face education. These codes opened the door for private payers and the Medicare Part D plans to reimburse community pharmacists for this valuable service.[5]

Advantages of Medication Therapy Management

The benefits of pharmacist delivered MTM services have been documented repeatedly. Specifically, the well known Asheville Project enlisted 12 community and hospital settings over a six-year period to significantly improve the clinical and economic outcomes in a cardiovascular risk reduction educational program.[6] In addition, data from the Connecticut Medicaid transformation project demonstrated, among other things, a 50% increase in the number of Medicaid patients who achieved their therapeutic goals, as a result of face-to-face pharmacist MTM services.[7] When the Medicare Modernization Act opened the door for reimbursable, pharmacist-delivered MTM services, pharmacists passionately embraced their expanded scope of practice. The Affordable Care Act, which places the coordination of care for patient outcomes in the patient-centered medical home, recognizes the value of the pharmacist as the "medication expert." Incorporation of the pharmacist in a patient-centered medical home holds the promise of enhanced communication and collaboration with the primary care physician as well as improved medication-related outcomes.

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