Pharmacists Emerging as Interdisciplinary Health Care Team Members

March 2013

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Dear Colleague

For pharmacists, the expanded access to our services by patients and the public is critical to enhanced medication use. For patient care to be optimized, pharmacists must be valued as members of the health care team. The 2010 Affordable Care Act (ACA) provided opportunities for pharmacists to expand their patient care services in a variety of traditional and innovative care settings. The Center for Medicare and Medicaid Innovation (CMS Innovation Center), which was created by ACA, also produced a number of expanded opportunities for pharmacists. Other developments in the MTM landscape have helped support ongoing improvements and advancement of MTM services, such as the ongoing development of quality measures and electronic health records.

This digest reports on the fifth “environmental scan” by the American Pharmacists Association (APhA) to assess the development and implementation of MTM services. Our findings demonstrate that MTM continues to be on a growth curve and that pharmacists’ value is being recognized in integrated care models. MTM services still face many challenges, particularly the need for more business models that are based on compensating pharmacists for the value they provide to the health care system. APhA has committed significant resources to assure consumers have access to pharmacists’ clinical services, including those provided in integrated care delivery models. Pharmacists must be valued members of the team! We are further committed to collaboration with other stakeholders as we have been throughout health care reform.

I extend great thanks to the researchers who were involved both in the expert advisory panel for the environmental scan as well as in the development of this issue of the Medication Therapy Management Digest for their insight and guidance to advance MTM services.

Sincerely,

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Impact of the Affordable Care Act
The Affordable Care Act of 2010 (ACA) has had an important impact on the development and expansion of medication therapy management (MTM) services and utilization of pharmacists in integrated care delivery models. ACA aims to expand health care coverage, improve quality, and control costs. The law is designed to achieve these goals by reforming the health care insurance market and encouraging innovation in the provision of health care services. ACA has faced many legal and political challenges. The 2012 U.S. Supreme Court decision to uphold most of the law, followed by the reelection of President Barack Obama, paved the way for ongoing implementation of the law.

Initiatives under ACA include activities driven by the Center for Medicare and Medicaid Innovation (CMS Innovation Center), the development of patient-centered medical homes and accountable care organizations (ACOs), and increased emphasis on care transitions. ACA established the CMS Innovation Center to encourage the development of scalable payment and service delivery models that reduce costs and improve the quality of care for Medicare and Medicaid. The law includes MTM services as one of the potential models to be tested. In addition, the CMS Innovation Center is focused on transitions of care, reducing hospital readmissions, and facilitating innovative ACO and medical home models. The CMS Innovation Center is directed to rapidly scale up models that are demonstrated to be successful. The law also included improvements to MTM services provided under Medicare Part D.

ACA’s focus on transitions of care has provided many opportunities for pharmacists to improve patient outcomes through the provision of medication reconciliation, patient education, and other medication management services. In 2012, the American Pharmacists Association (APhA) and the American Society of Health-System Pharmacists (ASHP) released a white paper, Improving Care Transitions: Optimizing Medication Reconciliation, that provides key recommendations for improving medication reconciliation, advocates for pharmacists to be involved on health care teams focused on care transitions, and positions improving medication reconciliation processes through MTM services.1 APhA and ASHP also launched the Medication Management in Care Transitions (MMCT) Project to identify and profile existing transitions of care best practice models. Eighty-two programs were evaluated through a stringent, competitive process. In October 2012, APhA and ASHP announced eight care transitions programs as best practices that improve patient outcomes, reduce hospital readmissions, and are scalable to facilitate broad adoption.2

ACA is expected to allow millions of previously uninsured individuals to obtain health insurance and seek primary care services. Since 2006, all U.S. schools and colleges of pharmacy have conferred only the doctor of pharmacy degree to graduates, representing a shift away from the previously available bachelor of pharmacy degree. Today’s graduates are all trained in the provision of patient care services, and their skills are greatly expanding the capacity of the pharmacist profession to provide patient care services. Combined with the ongoing development of interdisciplinary relationships between pharmacists and other care providers, pharmacists’ increased capabilities may help expand the capacity of the U.S. health care system to provide more efficient high-quality care.

CMS Activities related to Part D
Additionally, ACA directed the Centers for Medicare and Medicaid Services (CMS) to develop a standardized format for comprehensive medication review (CMR) documentation for beneficiaries enrolled in Part D MTM programs. The standardized documentation includes three components: a beneficiary cover letter, a medication action plan (MAP), and a personal medication list (PML). The format of these documents is similar to MTM forms currently in use (i.e., those included in the core elements model from APhA and the National Association of Chain Drug Stores Foundation). For example, the Part D PML is similar to the patient medication record (PMR) described in the core elements model.3,4 Medicare Part D plans are required to use the standardized format beginning January 1, 2013.

The written summary component of the Medicare Part D MTM standardized format requires performance of certain activities during the CMR to complete the documentation. These activities include discussion of beneficiaries’ concerns with their drug therapy; collection of the purpose and instructions for using their medications; review of their medications including prescription medications, nonprescription drugs, and supplements; and engaging beneficiaries in management of their drug therapy.5

CMS released a fact sheet that described the Part D MTM programs for 2012, which included 550 Medicare Advantage prescription drug plans and 83 stand-alone prescription drug plans.6 Among the findings of this review were:

- Pharmacists are the leading provider of MTM services across all MTM programs and are utilized by 99.5% of plans.
- Sponsors are continuing to refine their criteria for identifying beneficiaries. Almost 80% target beneficiaries with three or more
chronic diseases. Over 60% require beneficiaries to be taking eight or more Part D drugs.

• Every program offers CMRs via telephone, and 28.4% offer face-to-face CMRs.

CMS is focused on identifying potential opportunities to increase awareness of MTM programs among beneficiaries and their health care providers. The addition of the CMR completion rate to the Part D display measures is expected to increase the number of beneficiaries who receive CMRs.

Notable Initiatives and Reports
Progress in health information technology (HIT) and electronic health record (EHR) infrastructure development is allowing for increased exchange of information among providers including pharmacists. Expanded pharmacist access to EHRs is critical for efficient and effective provision of MTM services and tracking of outcomes. Ongoing developments are expected to further support the expansion of robust MTM services.

In 2011, for the first time in our history, the U.S. Surgeon General was presented with a comprehensive evidence-based report on pharmacy practice. After reviewing the report, the Surgeon General, Dr. Regina Benjamin issued a signed letter of support. The report is organized into four focus points:

• Focus Point 1 discusses how pharmacists are already integrated in many practice settings as health care providers through collaborative practice with physicians or as an essential part of a health care team.

• Focus Points 2 and 3 argue that for pharmacists to continue to improve patient and health care system outcomes as well as sustain various roles in the delivery of care, recognition as health care providers and compensation models reflective of the range of care provided are needed.

• Focus Point 4 provides an extensive review of evidence-based outcomes from pharmacist delivered care, aligned with demands on the health care system such as access, prevention, quality, and cost effectiveness.

Work of the Health Resources and Services Administration (HRSA) Patient Safety and Clinical Pharmacy Services Collaborative (PSPC) also has advanced the work of pharmacists. PSPC is designed to improve the quality of health care by integrating evidence-based clinical pharmacy services into the care and management of high-risk, high-cost, complex patients in community health centers and other federally qualified facilities. Clinical pharmacy services are provided by a multidisciplinary health care team through individualized patient assessment and management. According to HRSA, “These services are best provided by a pharmacist or by another health care professional in collaboration with a pharmacist.”

The value of MTM is increasingly being recognized by patients and patient advocates. In 2012, AARP released a report on the Medicare Part D MTM program advocating for MTM as a solution to the medication use problem in the United States. The report concluded that MTM programs “can serve as a bridge across care settings, and help to bolster clinician-patient interface around patient preferences and effective outcomes.”

Most recently, the IMS Institute for Healthcare Informatics issued a new report, The Responsible Use of Medicines: Applying Levers for Change, touting ways to save $500 billion in health care spending worldwide annually. The report identifies six strategies (i.e., levers) that can be applied by health system leaders to improve the use of medicines. One of the report’s recommendations for driving improvement is “supporting a greater role for pharmacists in medicines management.”

The Patient-Centered Primary Care Collaborative (PCPCC) recognizes comprehensive medication management services as integral part of patient-centered medical home models. The PCPCC resource, Integrating Comprehensive Medication Management to Optimize Patient Outcomes, provides information to facilitate the appropriate use of medications to control illness and promote health.

Results of the 2012 APhA MTM environmental scan illustrate the impact of these ongoing developments. As described in this year’s digest, MTM is moving forward and pharmacists are furthering relationships with patients, other practitioners, and organizational partners including those within emerging integrated care models. However, many important barriers remain. Efforts to increase efficiency of service delivery and expand payment opportunities are critical for the future of MTM.

The Fifth APhA MTM Environmental Scan

In 2007, APhA began conducting periodic environmental scans of providers and payers regarding their involvement with MTM services. Data from these surveys allow researchers to track progress and developments in the provision of MTM services and related programs over time.

Data collected for the first environmental scan in Fall 2007 showed that providers varied widely on how they implemented MTM service offerings and typically did not use specific measures to quantify the
costs and benefits of MTM. Although MTM providers did not use systematic methods for assessing value from providing MTM services to their patients, they did associate value with provision of MTM services as being part of their professional role in the health care system and society. The results of the 2007 environmental scan also showed that payers for MTM services varied widely on how they implemented and monitored their organizations’ MTM programs. They associated value of these programs with cost avoidance/minimization, improved member satisfaction, improved member medication compliance/adherence, and quality indicators (e.g., Healthcare Effectiveness Data and Information Set [HEDIS], National Committee for Quality Assurance).11–14

Results from the second environmental scan conducted in Fall 2008 were generally similar to the 2007 data. Notable differences included greater definition of MTM programs and services by greater numbers of respondents, revealing maturation among service providers and payers. However, the results from 2008 were similar to 2007 findings regarding: (1) MTM service structure; (2) value assessment of MTM services; (3) financial aspects (e.g., costs, billing, payment); and (4) barriers to provision of MTM.15

The third environmental scan conducted in Fall 2009 revealed that the progression and maturation of MTM service provision leveled off.15 Although the reasons for valuing MTM services as well as the challenges and barriers remained the same, many payers reported a reluctance to dedicate resources to MTM services. It is unknown whether the finding was a result of a challenging economy, variations in survey respondents from year to year, or a true shift in MTM development. Anecdotal evidence suggested that providers and payers who were not already invested in MTM services may have sought a more conservative strategy in 2009, electing not to pursue new, innovative services in a time of economic uncertainty. Conversely, in pockets of the country where MTM services were established, pharmacist-provided MTM services may have been embraced as a cost-saving strategy for overall health care systems through improved patient outcomes and efficient use of health care dollars.16

Results from the fourth environmental scan conducted in Fall 2010 found that MTM continued to grow and mature. In addition, consistent findings from year to year showed that some aspects of MTM had become established within the organizations that were providing and paying for these services. In 2010, there was an emergent “channel of distribution” for MTM service provision through which information, services, and payment were created and exchanged. In this new channel of distribution for MTM, we proposed that organizational relationships and cost efficiencies would be important considerations in the near term.17

In 2011, APhA, under the direction of the MTM Survey Advisory Board, conducted a study to summarize findings from the environmental scans conducted from 2007 through 2010. These findings were interpreted along with insights gained from the Future of Medication Therapy Management Roundtable convened in October 2010. Researchers also proposed ideas for future positioning and integrating of MTM programs.14, 18 Research on effective marketing strategies was used to interpret these findings.19–21

The advisory board concluded that there is a need for strategic planning related to understanding the size, structure, and behaviors of the target markets for MTM services. This strategy should focus on different relationships simultaneously to position and integrate MTM into the U.S. health care system. Other research that summarizes MTM survey articles published between 2004 and 2009 reached conclusions that are very similar to those of past APhA MTM environmental scans.22

The study described in this digest is the fifth environmental scan conducted by APhA under the direction of the advisory board to collect data from providers and payers about MTM service delivery. Of 7,925 providers who were sent an e-mail invitation to participate in the survey, 1,903 viewed the message and 427 returned a survey containing usable data. Of 949 payers who were sent an e-mail invitation to participate in the survey, 126 viewed the message and 57 returned a survey containing usable data. Both the payer and provider surveys used the pharmacy profession’s consensus definition of MTM, agreed to by 11 national pharmacy organizations.23 (Contact APhA at mtm@aphanet.org for more information about survey methods.)

The objective of the surveys of payers and providers was to gather information to answer the following questions:

1. What is the value associated with pharmacist-provided MTM services from the provider and payer perspectives?
2. What specific measures, if any, are providers and payers using to quantify MTM costs and benefits?
3. What are barriers to providing MTM services to individuals reported by providers and payers?
4. What methods/strategies are providers and payers using to incorporate pharmacists providing MTM services into new or emerging interdisciplinary team-based models of care (e.g., ACOs, medical home models)?
5. What strategies are providers and payers using to compensate pharmacists and pharmacies for services provided in new or emerging interdisciplinary team-based models of care?
6. What practice/organizational changes have providers and payers made from 2010 to 2012?

Results from these surveys were compared with those conducted in previous years to assess changes taking place in the market.
Providers Responding to Our Survey

Provider Characteristics

- Characteristics of providers responding to the survey have been generally similar from 2007 through 2012, which allows for comparison among findings and monitoring of trends.
  - The distributions of MTM provider respondents for the 2012 survey had proportionately fewer respondents from independent pharmacies and more from hospital pharmacies compared with previous years. This change may suggest that pharmacists in hospital settings are working more in integrated care models and care transitions activities and that they found this survey applicable to their practice to a greater extent compared with previous years.
- The most common job titles were staff pharmacist, clinical pharmacist, pharmacy manager, and consultant pharmacist.
  - In recent surveys, more MTM provider respondents described themselves as “clinical pharmacists” making this category one of the two most common job titles in 2009, 2010, and 2012. For reference, the most common job titles for 2008 and 2007 were “staff pharmacist” and “pharmacy manager.” This change may signify an important shift in how pharmacists who provide MTM services are beginning to refer to themselves and how they are being identified in their workplace.
- 75% of providers held a PharmD degree, which is much higher than the 24% seen in the 2009 National Pharmacist Workforce Survey, and represents an increase from the 47% in the 2010 provider survey.
- 28% had completed a residency, compared with 9% in the 2009 National Pharmacist Workforce Survey.
- 21% had participated in the MTM Certificate Training Program developed by APhA; 5% were Board Certified Pharmacotherapy Specialists and 2% were Board Certified Ambulatory Care Pharmacists.

Reflections From an MTM Provider

“[MTM] helps pharmacists operate at the top of their license, builds trusting and meaningful patient-pharmacist relationships, improves outcomes for patients and their quality of life.”

Provision of Services

- Overall, 68% of respondents reported providing MTM services as defined in the consensus definition.
  - Of those providing services, 8% had done so for less than 1 year, 21% provided services for 1 to 2 years, 26% provided services for 3 to 5 years, and 20% provided services for more than 5 years; 24% reported that they did not know.
- 42% of nonproviders reported that they were very likely or somewhat likely to begin providing services in the next 12 months. This percentage was similar to that reported in previous years (32% in 2010 and 36% in 2009).

Capacity to Provide Services

- Providers were asked to estimate the number of patients their practice provides MTM services to each week.
  - Then mean number of patients estimated to receive services was 39 (range 0 to 1,400), with a median of 6.
  - The median number of patients that providers could provide services to was 76, (range of 0 to 1,500).
Payers Responding to Our Survey

Payer Characteristics

- As seen in previous years, health maintenance organization/managed care organization was the most common type of organization represented in the survey.
- State Medicaid program representation increased from 2010 and previous years. The proportion of payers identifying as prescription benefit management companies (PBMs) dropped substantially from 2010 levels, which were significantly lower than those in 2008 ($P < .01$).
  - Organizational characteristics and job titles for payers fluctuated from one survey year to the next. These fluctuations and the relatively small sample sizes for payers should be considered when interpreting the findings from one year to the next.

Payer Provision of Services

77% of payer respondents reported offering MTM services as defined in the consensus definition.

- This percentage dropped somewhat from 86% in 2010, but remained elevated from the 62% reported in 2007.
- These findings were generated from a sample of organizations likely to be engaged in providing MTM programs and thus are not representative of all health care payer organizations in the United States. Rather, they provide insight from payers who are engaged in MTM service provision or are considering it for their organization.

Table 2.2.1

<table>
<thead>
<tr>
<th>Organization</th>
<th>Percent of Respondents</th>
<th>2012 (n=37)</th>
<th>2010 (n=33)</th>
<th>2009 (n=50)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO/managed care organization</td>
<td>27</td>
<td>36</td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>State Medicaid program</td>
<td>12</td>
<td>16</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Insurer</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>MTM program administrator</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Medical home</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Prescription benefit management company</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>MTM contract vendor company</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Claims administrator</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Accountable care organization</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Self-insured employer</td>
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<td>1</td>
<td>1</td>
<td></td>
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<tr>
<td>Insurance co-op</td>
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<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Benefits coalition</td>
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<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

*This item was not offered as an option in this year’s survey.

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Reflections From an MTM Payer

“MTM results in high Payer satisfaction, improved patient outcomes, and reduced total cost of care.”
Who Is Receiving Services?

Eligibility by Insurance Coverage—Providers

- Providers reported providing MTM services to patients with diverse types of insurance.
- In 2008, 2009, 2010, and 2012, the four most common insurance types that patients had were:
  - Medicare Advantage plans.
  - Medicare supplemental plans.
  - Commercial health insurance (health and/or prescription coverage).
  - Stand-alone prescription drug plans.

![Insurance Types of Patient Populations Receiving MTM Services from Providers](image)

### Successful Marketing Strategies for MTM Providers

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percent of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct contact with patients</td>
<td>75</td>
</tr>
<tr>
<td>Collaboration with other health care providers</td>
<td>47</td>
</tr>
<tr>
<td>Word-of-mouth promotion</td>
<td>31</td>
</tr>
<tr>
<td>Health and wellness screenings and other in-pharmacy activities</td>
<td>21</td>
</tr>
<tr>
<td>Developing contractual relationships with payers</td>
<td>18</td>
</tr>
<tr>
<td>Distribution of printed material including prescription inserts and posters</td>
<td>15</td>
</tr>
<tr>
<td>Advertisements (e.g., print, radio, television)</td>
<td>8</td>
</tr>
<tr>
<td>E-mail communications</td>
<td>7</td>
</tr>
</tbody>
</table>

Similar data are not available from previous years.

Reflections From an MTM Provider

“MTM services have provided value to our organization by continuing to build relationships with our patients and validating pharmacists as health care professionals from the patient perspective.”

DoD = Department of Defense; HMO = health maintenance organization; PHS = Public Health Service; PPO = preferred provider organization; SNP = special needs plans; VA = Veterans Affairs.

Other included: hospice, free clinic, clinical trial, uninsured, or indigent.

*This item was not offered as an option in this year’s survey.*
Strategies for Identifying Patients—Providers

- In both 2008 and 2009, the top three ways that providers identified potential candidates for MTM services were:
  - Patients having specific disease states (e.g., asthma, diabetes).
  - Patients with a specific health plan.
  - Patients taking a specific number of medications.

- In light of these findings, the question was changed in 2010 to evaluate how patients were referred for MTM services.
  - The most common method was for patients to be referred by an MTM vendor (53%), followed by health plan or PBM referral (41%), prescriber or physician referral (37%), or through self-referral (35%).

- In 2012, the question was changed again to focus on the proportion of patients entering the MTM service from various referral sources.
  - The greatest proportion of patients were referred by an MTM vendor (e.g., OutcomesMTM, Mirixa), followed by referral through collaboration with another practitioner.

- Providers were questioned in 2012 about which marketing strategies had been most successful.
  - 75% reported that direct contact with patients was the most successful marketing strategy. Collaboration with other health care providers and word-of-mouth promotion were the second and third most successful strategies, respectively.
  - This question did not directly match any asked in previous years.

Integrated Care Models

- In 2012, providers were asked for the first time about the provision of MTM services within integrated care models, such as accountable care organizations and medical homes.
  - 31% of those who responded to this question (n=67) reported that they provided services in an integrated care model.
  - The most common models were a medical home model (15%), followed by a transitions in care model (10%), ACOs (4%), and other (7%).
  - Of the 67 providers providing services in integrated care models, 57% were paid a salary, 27% received fee-for-service payments, and 16% contracted for services.

- Among pharmacists providing services in integrated care models (n=67), activities included:
  - Medication management services (33%)
  - Patient education (32%)
  - Drug information (27%)
  - Medication reconciliation (25%)
  - Medication Adherence services (24%)
  - Chronic disease management (23%)
  - Prevention and wellness services (15%)

Reflections From an MTM Provider

“Our MTM service shows patients how pharmacists can help manage their medications. They are often surprised by the knowledge base a pharmacist has, which I believe helps build stronger trust with future recommendations and prescriptions.”
Eligibility by Insurance Type—Payers
- As seen in 2008, 2009, and 2010, Medicare Advantage plans were the most frequently reported coverage type conferring eligibility for MTM services, followed by Medicare stand-alone prescription drug plans. State Medicaid programs were the third most common coverage type, up to 38% from 17% in 2010.
- 10% of payers offered services as part of a medical home, and 7% offered services as part of an ACO.
- The number of payers who offered services through a Medicare stand-alone prescription drug plan dropped to 17% from 47% in 2010.

Eligibility by Patient Characteristics—Payers
- Payers were most likely to report patient eligibility based on a specific number of medications (79% of payers).
- As in 2008, 2009, and 2010, other common strategies for determining patient eligibility were specific disease states, a specific number of disease states, and specific drug spends.
Strategies for Identifying Patients—Payers

• Payers reported several strategies for identifying patients eligible for services. Pharmacists were most likely to identify patients (52%), which was an increase from 40% in 2010 and 31% in 2008. Pharmacists were second most likely (45%) to identify patients in 2012, down from 70% in 2010 and 55% in 2008.

• Physicians identified patients for 10% of payers.

• Patients were identified by “other” 31% of the time. Written responses for this category included: all are eligible, IT department, nurse, case manager, disease manager, social worker, PBM, and vendor.

• Payers also were questioned regarding the most successful strategies for publicizing MTM services.
  - Direct communication with patients was clearly the most successful marketing strategy, reported by 86% of payers.
  - Word-of-mouth promotion was reported as a successful marketing strategy by 21% of payers, followed by developing contractual relationships with providers 18%.

![Diagram showing identification methods for MTM services]

![Bar chart showing successful marketing strategies for MTM services]
How Are Services Provided?

Use of the Core Elements Model—Providers

• In 2008, 2009, and 2010, the majority of providers included components of the core elements of MTM services in the activities/services they “often” or “always” provided.

• The most common activities/services in 2012 were:
  – Maintain documentation (77%).
  – Provide an intervention/recommendation to prescriber (68%).
  – Create a personal medication record/list (65%).
  – Conduct a comprehensive medication review (63%).

• Providers also were asked to further describe their provision of services. When providing MTM services to an individual patient, providers (n=229) routinely include:
  – Collection of data/information from patient (93%).
  – Assessment (89%).
  – Development of goals/plan of care (81%).
  – Implementation of the plan of care (67%).
  – Monitoring of the plan or transition (64%).
  – Evaluation of the plan of care (58%).

• When asked about activities provided as part of MTM services, providers (n=229) reported:
  – Disease state management (73%).
  – Immunizations (63%).
  – Medication reconciliation (62%).
  – Medication adherence services (59%).
  – Health and wellness screenings (41%).

Use of the Core Elements Model—Payers

• As in previous years, the majority of payers reported that many MTM services were provided “often” or “always.”

• Activities that payers offered as part of MTM services included:
  – Medication reconciliation (90%).
  – Medication adherence services (77%).
  – Disease state management (61%).
  – Disease state education (58%).
  – Educational mailings (55%).
  – Smoking cessation (42%).
  – Immunizations (29%).
  – Nutrition and weight loss (26%).
  – Transition of care services (19%).
  – Health and wellness screenings (13%).

Written comments about how pharmacists work with other team members in the integrated care model revealed several insights:

• Pharmacists work side by side with other team members.
• Collaboration and respect for what each team member provides is applied to the teams.
• Coordinated communication is vital for success in the integrated care model.
• Pharmacists are positioned as “air traffic control” for medication management.
• Referrals and “hand-offs” abound in the integrated care model.
• Protocols are used for care coordination among team members.
Disease State Management—Providers and Payers

- Within MTM, the disease states managed by providers and the disease state management programs reported by payers were similar. The most common disease states are those largely managed by the use of medications, indicating a growing recognition of the role of pharmacists in contributing to the care of patients with these conditions.

Delivering the Services—Payers

- As in 2008, 2009, and 2010, “pharmacists in-house” was the most commonly used provider for the delivery of MTM services, used by 55% of payers, followed by contracted pharmacists (48%), and contracted MTM provider organizations (34%).
- Utilization of in-house nurses declined from 29% in 2008, to 20% in 2009 and 17% in 2012. However, the small sample sizes must be considered when interpreting these findings.
- Payers’ written responses to “other” providers utilized included the terms “certified pharmacist” and “health educators.”
- 86% of payers reported that services were delivered using telecommunication (including phone and televideo), and 52% reported that services were delivered face-to-face in person.
  - These data are similar to those reported in 2008, 2009, and 2010.
- 10% of organizations used a tiered approach to service provision in which some members received a phone intervention, followed by a face-to-face intervention for a subset of patients.
- As in previous years, the majority of payers reported that only a subset of patients who are eligible for services actually participate in the services.

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Providers (n=168)</th>
<th>Payers (n=19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>77%</td>
<td>89%</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>70%</td>
<td>84%</td>
</tr>
<tr>
<td>Respiratory disease (e.g., asthma, chronic obstructive pulmonary disease)</td>
<td>52%</td>
<td>63%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>49%</td>
<td>84%</td>
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<tr>
<td>Anticoagulation therapy</td>
<td>45%</td>
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</tr>
<tr>
<td>Pain management</td>
<td>32%</td>
<td>37%</td>
</tr>
<tr>
<td>Bone or joint disease (e.g., arthritis, osteoporosis)</td>
<td>29%</td>
<td>37%</td>
</tr>
<tr>
<td>Mental health</td>
<td>24%</td>
<td>37%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>21%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Payers Who Report Services Provided to Eligible Patients “Often” or “Always” Multiple Responses Allowed

- Maintain documentation
- Provide an intervention/recommendation to prescriber
- Create a personal medication record/list
- Conduct a comprehensive medication review
- Develop a patient medication-related action plan
- Provide follow-up
- Develop a professional care plan
- Provide an intervention/recommendation to prescriber
- Participate in transitions of care
- Provide an intervention/educate the patient

Proportion of Those Eligible Who Participate in MTM Services as Reported by MTM Payers

- More than 90%, but less than 100%
- 75% to 90%
- 50% to 74%
- 25% to 49%
- Less than 25%
- Don’t know
- Not applicable

Table 6.2.4

<table>
<thead>
<tr>
<th>Disease State</th>
<th>Providers (n=168)</th>
<th>Payers (n=19)</th>
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<tr>
<td>Diabetes</td>
<td>88%</td>
<td>95%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>77%</td>
<td>89%</td>
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<tr>
<td>Dyslipidemia</td>
<td>70%</td>
<td>84%</td>
</tr>
<tr>
<td>Respiratory disease (e.g., asthma, chronic obstructive pulmonary disease)</td>
<td>52%</td>
<td>63%</td>
</tr>
<tr>
<td>Heart failure</td>
<td>49%</td>
<td>84%</td>
</tr>
<tr>
<td>Anticoagulation therapy</td>
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<tr>
<td>HIV/AIDS</td>
<td>21%</td>
<td>16%</td>
</tr>
</tbody>
</table>
Value Associated with MTM Services

Perceptions of Value—Providers
• As seen in previous years, the greatest value of providing MTM services was increased professional satisfaction, followed by increased patient satisfaction, and increased quality of care/outcomes based on performance measures.
• Revenue generation and other financial factors were not rated as highly.
• Written comments indicated that MTM service development during 2012 was helping pharmacists become more integrated with their patients and with the overall health care team by:
  – Building connections with patients.
  – Building professionalism.
  – Creating collaboration.
  – Enhancing the pharmacist’s image with the public and colleagues.
  – Obtaining a new level of respect from patients.
  – Increasing patient–prescriber–pharmacist interaction.
  – Establishing trust with patients.
  – Achieving more personal interaction with patients.
  – Feeling more a part of the health care team.
  – Increasing patient loyalty.
  – Improving patients’ perception of the value of the services offered by pharmacists.
• Some pharmacists mentioned the need for new models such as the patient-centered medical home to help form structures and processes for enhanced patient care collaborations.

Value From Services—Payers
• As in previous years, all factors associated with value were rated as “significant” by payers.
• Increased quality of care/performance measure outcomes was the primary factor for payers, followed by reduced costs of medical care and reduced total health care costs.
• Written comments indicated that payers derived value from:
  – Improved patient outcomes.
  – High patient satisfaction.
  – Reduced cost of care, including reduced emergency department costs and reduced medical costs.
  – Improved interdisciplinary care.
  – Improved medication utilization, including avoidance of adverse events and drug interactions.
  – Retaining membership in the organization.
Based on payers’ written comments, MTM provides value in economic (e.g., cost of care), clinical (e.g., health outcomes), and humanistic (e.g., stronger relationships) outcomes. Several comments focused on improved relationships with patients, member retention, member satisfaction, having a “personal pharmacist,” addressing and resolving members’ concerns, building understanding and confidence, having a “high-touch” approach, and the ability to identify “significant actionable items.”
Monitoring the Outcomes—Payers

- In contrast to previous years, improved adherence and member satisfaction were the outcomes most commonly measured by payers.
- Several outcomes were shown to be improved by MTM services, including inappropriate medications in elderly patients (Beers criteria), HEDIS, Pharmacy Quality Alliance (PQA) measures, and CMS star ratings.
- Comprehensive medication review (CMR) completion rates are being evaluated by CMS.
  - CMS has stated, “Plan sponsors are expected to actively engage beneficiaries to increase the number of CMRs delivered to MTM enrollees, not just ‘offer’ CMRs.”
  - The findings suggest that, in 2012, payers’ strategies for implementation and evaluation of MTM were becoming more sophisticated in that they were able to focus on their organizations’ goals and on the goals of meeting external quality metrics (e.g., CMR completion rates, Beers criteria, PQA measures, and CMS star ratings).

Based on written responses by MTM payers, processes they implemented in the past 3 years to improve the quality of MTM services delivered included:

- Electronic systems for managing data.
- Collaboration with other organizations for member identification and member screenings.
- Integrating MTM programs with other areas.

Reflections From an MTM Provider

“MTM has decreased the number of readmissions for patients with CHF [congestive heart failure], ACS [acute coronary syndrome], and pneumonia. It has also decreased the number of readmissions/adverse events caused by anticoagulation therapy in post-op orthopedic patients.”

Reflections From an MTM Payer

“MTM services have reduced inappropriate medication use, reduced emergency department use, and minimized adverse events and drug interactions.”
Looking at Challenges and Barriers for MTM Services

Challenges and Barriers for Providers
As in 2010, the greatest challenge/barrier for providers was a lack of insurance companies paying for MTM services.

The next most prominent barrier was “pharmacists have inadequate time,” which was an increase from previous years.

“Payment for MTM Services is too low” was the third most important barrier.

“Inadequate support staff,” “patients do not keep appointments,” and “too few MTM patients to justify the cost” were first added to the survey in 2012.

### Challenges/Barriers When Providing MTM Services Among Providers

<table>
<thead>
<tr>
<th>(mean rankings)</th>
<th>(Based on 5-point scale where 1 = very insignificant and 5 = very significant, n=213)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very significant</td>
<td>(No items ranked in this category)</td>
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<tr>
<td>Significant</td>
<td>Lack of insurance companies paying for these services (3.7)</td>
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<tr>
<td></td>
<td>Pharmacists have inadequate time (3.6)</td>
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<tr>
<td></td>
<td>Payment for MTM services is too low (3.6)</td>
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<tr>
<td></td>
<td>Billing is difficult (3.5)</td>
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<tr>
<td>Neither significant nor insignificant</td>
<td>Inadequate support staff (3.4)</td>
</tr>
<tr>
<td></td>
<td>Patients are not interested or decline to participate (3.3)</td>
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<tr>
<td></td>
<td>Patients do not keep appointments (3.3)</td>
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<tr>
<td></td>
<td>Trouble communicating/marketing to patients (3.2)</td>
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<td></td>
<td>Lack of collaborative relationships with prescribers (3.2)</td>
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<td></td>
<td>Documentation for services is difficult (3.0)</td>
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<tr>
<td></td>
<td>Inadequate space is available (2.9)</td>
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<tr>
<td></td>
<td>Too few MTM patients to justify the cost (2.8)</td>
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<tr>
<td></td>
<td>Technology barriers (2.8)</td>
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<tr>
<td></td>
<td>Too difficult to determine patient eligibility (2.7)</td>
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<tr>
<td></td>
<td>Unable to collect or access needed patient information (2.6)</td>
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<tr>
<td></td>
<td>Inadequate training/experience (2.6)</td>
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<tr>
<td>Insignificant</td>
<td>Management does not support provision of MTM services (2.2)</td>
</tr>
<tr>
<td>Very insignificant</td>
<td>(No items ranked in this category)</td>
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</table>

Reflections From an MTM Provider
“Our MTM services provide an invaluable resource to both our patients and providers. We are able to spend the time necessary to educate our patients regarding their disease states, medications, and treatment plan options that would normally be missing in their current health care. There is also an element of job satisfaction for our pharmacists who are currently providing these services at our clinic sites. We are hoping to grow and expand our services as we become more financially capable of doing so.”

Reflections From an MTM Provider
“We reduce medication costs, medical costs due to adverse effects, and improve quality of life for our patients. We have also developed a good working relationship with the physicians and nurses by proving our value.”
Challenges and Barriers for Payers

• The most prevalent barriers to providing MTM services reported by payers in 2012 were:
  - Patients are not interested or decline to participate; this was the only challenge ranked as significant.
  - Skeptical that these types of services would produce tangible outcomes.
  - Providers do not have the training/experience.
  - Resistance or lack of acceptance by physicians or other health care providers; this item was new in 2012.

• Written comments from 2012 indicate that payers have challenges related to:
  - Patient participation in the program.
  - Finding a software platform that meets the needs of the program.
  - Communicating with members.
  - Lack of standardized documentation and billing mechanisms.
  - MTM payers also continue to have logistical challenges related to: raising consumer awareness of MTM, engaging patients in the service, enrolling members and getting them to participate in MTM programs, achieving scalability for MTM programs, and conducting outcomes assessment.

### Barriers to Providing MTM Services Reported by MTM Payers

<table>
<thead>
<tr>
<th>(mean rankings)</th>
<th>(Based on 5-point scale where 1=very insignificant and 5=very significant, n=30)</th>
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<tr>
<td>Very significant</td>
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<tr>
<td>Significant</td>
<td>Patients are not interested or decline to participate (4.1)</td>
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<td>Neither significant nor insignificant</td>
<td>Skeptical that these types of services would produce tangible outcomes (3.4) Providers do not have the training/experience (3.1) Resistance or lack of acceptance by physicians or other health care providers (3.0) Eligible patients do not really need it (2.9) Insufficient MTM providers in the market area to meet needs (2.9)</td>
</tr>
<tr>
<td>Insignificant</td>
<td>Too few MTM patients to justify the cost (2.2)</td>
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<tr>
<td></td>
<td>Too difficult to determine patient eligibility (2.1)</td>
</tr>
<tr>
<td>Very insignificant</td>
<td>(No items ranked in this category)</td>
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</table>

### Reflections From an MTM Payer

“**The value of MTM to our organization is in improved adherence and coordination of care. It helps patients to understand their medication therapy and feel more confident.**"
Financial Aspects of MTM Services

Costs to Run an MTM Service
- The greatest cost associated with running the MTM service was the pharmacists’ time, followed by pharmacists’ training.
- 83% of providers reported that the investment in MTM was worth it from the organization’s perspective.

Return on Investment for Providers
In 2012, pharmacists were asked to compare the revenue generated by the provision of MTM services with the amount invested to provide MTM services to determine the return on investment (ROI).
- The majority (79%) reported that they did not know their ROI.
- Of those who had ROI information, 60% reported an ROI <1:1, 10% reported an ROI of 1:1, and 30% reported an ROI >1:1.
- These data demonstrate that it is crucial for MTM processes and payment mechanisms to evolve to support financially viable business models.

Pharmacist Compensation
- Payment for providing services as part of the standard pharmacist salary continued to be the method of compensation for the overwhelming majority of providers.

Payment for Services
- 63% of providers reported billing for MTM services, which was similar to the 68% in 2010 and 57% in 2009.
  - Among payers, 28% reported using CPT codes for MTM claims processing.
    - Among providers who billed, 39% reported that 100% of visits were paid for by patients or plans; another 21% reported that payment was received for 76% to 99% of visits.
    - Of those who were not billing for MTM services, written responses revealed some insights. Providers (1) had not yet set up billing capacity; (2) were funded through mechanisms for which there was no need to bill (e.g., grants, federal funding, part of bundled services); or (3) were not involved with billing aspects at their organization.
    - As in previous years, providers reported a variety of fee structures for MTM services, including:
      - 58% use a fee-for-service basis.
      - 49% use a flat rate per service.
      - 9% use a capitated rate.

Return on Investment for Payers
- 29% of payers were able to report an ROI for services.
  - This was an increase from only 9% in 2009 and 21% in 2010.
  - Those who reported an ROI provided answers ranging from 1:2 to 4.5:1, with the majority of answers clustered from 2:1 to 3:1.
  - These data demonstrate that payers, on average, are seeing a positive ROI in MTM services and underscore the need for the development of payment models that support financial viability of MTM services for providers.
Changes Experienced in 2012—Providers

- 70% of providers saw an increase from 2010 to 2012 in the number of patients receiving MTM services, with 49% reporting a moderate or significant increase.
- Several providers made changes in their practice to accommodate increased MTM service demands.
  - 24% adjusted pharmacists’ schedules to facilitate service delivery.
  - 23% added full-time pharmacist employees.
  - 10% remodeled facilities.
- Contract opportunities generally increased from 2010 to 2012.
- Provider respondents were asked: “What is your organization’s most important goal for 2013 relating to MTM services?” Based on their written responses, several themes emerged:
  - Service expansion and growth.
  - Improve compensation for MTM services.
  - Increase patient awareness and patient engagement in MTM services.
  - Coordination of MTM service offerings into integrated care models.
  - Work system design improvement.
  - Electronic records and standardization for improved efficiencies.
  - Develop ways to demonstrate value for services provided.
- The goals listed are consistent with findings presented in other sections of this report.

Changes Experienced in 2012—Payers

- Many payers (54%) reported a moderate or significant increase in the number of patients receiving MTM services.
- Many payers’ organizations made modifications from 2010 to 2012. These included:
  - Enhanced MTM program offerings to beneficiaries for 2012 (46%).
  - Increased in-house provider staff (36%).
  - Contracted with MTM network service provider to administer program for 2012 (11%).
  - Increased contracted provider staff (25%).
- Payers were asked to indicate the percent of their beneficiaries receiving MTM services who have the service provided by contracted community pharmacists.
  - 50% responded “none” and another 32% indicated less than 25%.
  - Only 4% reported more than 50%.

Change in the Number of MTM Patients from 2010 to 2012—Providers

Change in the Number of MTM Patients from 2010 to 2012—Payers
Overall Contribution of the Pharmacist to Patient Care Is Invaluable

The University of Utah Hospitals and Clinics

As an integrated health delivery system with 6 hospitals and more than 30 clinics with 15 ambulatory care pharmacies, the University of Utah is a progressive health care organization that embraces the role of the pharmacist and sees the pharmacist as an invaluable component of patient care. Seven practice sites are part of an integrated care program with clinical pharmacists providing a variety of patient care services including MTM. Under collaborative practice agreements, pharmacists have the authority to initiate, modify, refill or discontinue medications for certain conditions. Additionally, pharmacists always analyze the entire patient profile and provide recommendations to the primary care provider for disease states not covered by the agreements.

Advanced patient care services provided by pharmacists include pre-visit planning, disease state education and training, and services defined in disease state collaborative practice agreements. Pharmacists provide disease state management for patients with chronic conditions including diabetes, dyslipidemia, and hypertension.

As part of the pre-visit planning program, patient’s records are reviewed 2 weeks before the patients are scheduled to see their primary care providers. Brandon Jennings, PharmD, clinical coordinator of pharmacy ambulatory care services, explains that this step determines which patients would benefit from an MTM review prior to their visit. Patients who have more complex medication needs are called and scheduled to have a visit with the clinical pharmacist about 1 week before the provider visit.

Pharmacists also work with the organization’s IT department to proactively identify patients who could benefit from MTM. For example, patients with uncontrolled chronic conditions can be identified by reviewing EHRs for high-risk criteria, such as elevated A1C levels. The entire outpatient network uses EHRs that allow for documentation and facilitate communication within the university’s health system. Use of EHR technology helps facilitate identification of patients with unmet needs who can benefit from pharmacy services.

The hospital and clinics also have a robust transitions of care program. Pharmacists reconcile patients’ medications upon admission, during hospitalization, upon discharge, and again when patients return to the outpatient clinic. When patients are discharged, the pharmacist places a discharge note in the EHR for the next care provider. In community clinics, providers receive a daily e-mail that lists all patients who were discharged from the hospital. The outpatient care manager reviews the discharge records, verifies follow-up appointments, and calls patients to determine whether they have any questions or concerns since discharge. If the patient has complex medication issues or is considered high risk, a follow-up appointment is scheduled with the pharmacist before the primary care provider to allow an opportunity for medication education and recommendations.

Compensation for Services

Because the integrated care program operates as a hospital-based clinic, many of the pharmacists’ clinical services can be billed using...
a facility charge that is compensated by Medicare and Medicaid. However, “The overall mission of the university to provide excellent patient care that advances pharmacy practice is critical for supporting current services,” explains Dr. Jennings. Thus, not all of the pharmacists’ services are currently cost-justified. The clinics are owned by the university, and all pharmacists are employees of the university.

The services that clinical pharmacists provide increase other revenue through appropriate ordering of laboratory tests and increased prescription volume. In addition, patients who receive clinical pharmacy services become more actively involved in their care and are less likely to be “no shows” for visits.

Beginning January 1, 2013, the University of Utah’s health care system will become an ACO, and the system is contracted to provide care to 25% of patients enrolled in the Utah Medicaid program. Compensation from Medicaid will be provided on a capitated basis; therefore, provision of care that produces overall savings will financially benefit the program.

**Physician Perspectives**

The physicians who work with the clinical care pharmacists consider them to be invaluable. According to Margaret Solomon, MD, who practices internal medicine at one of the clinics, “It is incredibly helpful for us to work as part of a team with the pharmacist.”

Pharmacists typically perform consistent weekly follow-up with medication titration and management. By comparison, prescribers typically see patients once every 3 months. “Because the pharmacists are able to follow-up regularly with the patients, it extends the care that we can provide,” notes Dr. Solomon. Furthermore, the more frequent contact improves the effect of the interventions. “When patients come in every 3 months, it is difficult to get their conditions under control. But, once the pharmacist gets involved, patients become much more adherent to their care and we see a dramatic impact. If you know someone is going to be calling you every week, you are more likely to do what you are supposed to be doing,” she continues.

Dr. Solomon reports that the increased level of interaction between the pharmacist and the patient improves communication and helps address barriers. “Sometimes patients do not feel comfortable telling their physician what is really happening. But, when they have someone accessible who they can talk with regularly, they are more willing to open up about their problems.”

Pharmacists’ preclinic visits also greatly increase the efficiency of the patients’ visits with physicians. “Before this service, the physician might spend most of the visit just trying to sort out which medications the patient is taking. Now, we can scan the pharmacist’s SOAP note and it takes 2 minutes instead of 20,” explains Dr. Solomon. “This is crucial because there is a limited amount of time we can spend with each patient. Now we can focus that time on things only a physician can do.”

Dr. Solomon also acknowledges that pharmacists have a very high level of expertise about medication management issues and ensuring that patient care aligns with recommended guidelines. She notes, “Pharmacists are very good at identifying unmet needs, such as the need for a vaccine or laboratory test.”

Julia Ozbolt, MD, another internal medicine physician at the clinic, echoed the sentiment that their pharmacists are invaluable. “They have added so much to our ability to manage multiple patients, and we can accomplish so much more with each visit. Care is more effective and safer,” she says. “Once the pharmacist becomes involved, we often see rapid improvements in patients who have been uncontrolled for years.” For example, patients with diabetes who enter the program have an average A1C reduction of 2.5% over 6 months.

“Overall, providers recognize that pharmacists are invaluable for improving patient care and avoiding costly occurrences such as [emergency department] visits and hospitalizations. They maximize our facility’s preventive medicine and patient care,” observes Dr. Solomon.
Clinical Pharmacists Elevate the Level of Care for Underserved Populations:

Health Partners of Western Ohio
Health Partners of Western Ohio (HPWO) is an integrated ambulatory health care program that combines medical, dental, alternative health, behavioral health, clinical pharmacy, and dispensing pharmacy services under one roof. Patients typically see multiple health care providers—including clinical pharmacists—in a single visit to one of the three clinics run by HPWO. HPWO is a Federally Qualified Health Center (FQHC). As an FQHC, Health Partners does not turn away any patients due to the inability to pay and many patients are either uninsured or underinsured. If applicable, insurance will be billed for services. Patients have the option to apply for sliding fee discounts on services according to federal poverty guidelines and organizational policy. The clinic uses the federal 340b Drug Pricing Program as well as a variety of manufacturers’ prescription assistance programs to help patients afford their medications.

Jennifer Clark, BSPharm, Director of Pharmacy Services for HPWO, describes the development of the program’s comprehensive pharmacy services. “The health center started in 2003 with $5,000 and a plan to apply for FQHC status.” In late 2004, the health center was able to obtain the federal grant funding and utilize the 340b program to offer sliding fees on prescriptions for eligible clinic patients. The program’s goal always has been to offer clinical pharmacy services and these were initiated in 2008 when HPWO joined with the PSPC program through HRSA. By documenting the pharmacist’s impact on health outcomes through this collaborative, HPWO applied for and received a pharmacy expansion grant from HRSA to help offset the cost of implementing services. Under the FQHC model, HPWO can use profit from dispensing to enhance services. Thus, resources from the dispensing pharmacy are able to support clinical pharmacy services on an ongoing basis.

The Patient Care Model
HPWO’s clinical pharmacy team sees patients who are referred by other members of the health care team. Those providers identify patients who have complex medical needs and could benefit from the clinical pharmacy program. According to Clark, “Many of the patients who are referred for clinical pharmacy services have not had medical care for many years, have low literacy, have multiple chronic diseases, and require a lot of attention.” All patients who use five or more chronic medications are offered at least one annual clinical pharmacy review. Patients also may have visits throughout the year as issues arise.

Clinical pharmacy uses a block schedule for MTM and disease management visits. In addition, pharmacists are sometimes able to coordinate with the nurse practitioners or physicians to see patients during the same visit. Typically, if another provider identifies a need for clinical pharmacy services, the pharmacist is able to accommodate the request. Patients needing the service may also be identified through organizational disease management and outcomes programs.

The clinical pharmacy program that began over 4 years ago now includes general MTM, evaluation, and continued intervention. Disease state management services address conditions including diabetes, hepatitis C, hypertension, asthma, chronic obstructive pulmonary disease, and hyperlipidemia. Pharmacists perform some point-of-care testing, such as spirometry and A1C testing; they also can order laboratory tests and have results available prior to the patient’s next visit.

A robust EHR system is crucial for efficient and effective care at Health Partners. Traditional dispensing software programs are used to manage all the dispensing pieces, and the dispensing pharmacist has complete access to the patient’s full EHR. The clinical pharmacists also have access to the patient’s EHR and document care using the same system.

A Tremendous Impact on Patient Outcomes and the Overall Care Team
The impact of the clinical pharmacy services on patient outcomes has been tremendous both objectively and subjectively. “It is not unusual for our patients with diabetes to see their A1C drop by 3 or 4 points,” notes Clark.

According to Janis Sunderhaus, MSN, the program’s chief executive officer, having the clinical pharmacist on the patient care team improves the level of care provided by other team members. “Without the pharmacist, the nurse practitioner or physician might
spend most of the patient visit trying to sort out their medications. If the pharmacist has already done that and provided recommendations for modifications to the care, that allows the provider to use limited time with the patient much more efficiently.” As a result, patients’ needs are addressed at a much more comprehensive level.

“Pharmacists bring a very deep level of knowledge about the use of medicines to manage chronic diseases that has a profound impact on patient care,” explains Sunderhaus. She also says that pharmacists are the perfect profession to bridge between the primary care providers and specialists. Sunderhaus continues, “As a patient care bridge, they can address issues such as polypharmacy and prescribing cascades. Pharmacists are trained to look at the whole prescribing picture for each patient in ways that other providers generally do not.”

Sunderhaus further notes that having the pharmacist as a member of the interdisciplinary team elevates the level of care provided by all team members. “When the pharmacist becomes part of the team, care is provided at a much higher level that challenges everyone to promote best practices. The pharmacist elevates the entire practice and compels all team members to be their best.” HPWO’s preliminary data from October 2011 through November 2012 show 930 documented clinical pharmacy interventions for 575 high-risk patients. Of these interventions, the team identified and addressed 728 medication-related problems including 63 adverse drug events and 481 potential adverse drug events. The program is working to develop a methodology for calculating the actual cost savings generated by the clinical pharmacy services.

Patients are overwhelmingly positive about the pharmacists’ role in their care. “Patients are very grateful for the care they are receiving and the care is unprecedented in the community,” remarks Sunderhaus. For most patients, having someone ask the right questions to make sure they take their medications correctly, and explore their questions is a new experience. “Patients feel more valued because of the attention they receive from the pharmacist.”

HPWO is working to gain recognition for the high level of care provided. The organization recently earned accreditation from the Accreditation Association for Ambulatory Health Care. This accreditation is a voluntary process through which a health care organization is able to measure the quality of its services and performance against nationally recognized standards. The program is also pursuing the highest level of NCQA medical home recognition (level 3).

Opportunities to Expand

HPWO is constantly looking for opportunities to expand pharmacists’ services to meet the needs of patients with complex health care issues. HPWO is expanding their scope of service to include a project in Northwest Ohio to provide an integrated care model, including pharmacists’ services, to patients with severe mental illness. The program serves as a teaching site for student pharmacists from two area universities on introductory and advanced pharmacy practice experience rotations. HPWO also runs a postgraduate year one community pharmacy residency program with a strong ambulatory care component under the direction of Micah Sobota, PharmD, BCPS, CGP. “We truly believe in building the next generation of pharmacy providers and have a very strong commitment to the students and residency programs,” reports Dr. Sobota. “This training is crucial so that next generation of pharmacists is prepared for the future of pharmacy care.”

The greatest barrier to further expansion of the program is pharmacists’ lack of provider status for Medicare Part B, and the resulting lack of payment for services. More reliable compensation for services that is commensurate with pharmacists’ training and experience is critical for the ongoing development of a sustainable, affordable, effective model. Despite this barrier, HPWO is constantly exploring opportunities to develop new revenue streams, including collaborations with managed care plans, hospitals, and other health care decision makers.

Notably, HPWO works closely with state legislators, which opens the channel of communication to advocate for increased pharmacist integration in state level activities. Dr. Sobota explains, “We keep working to communicate the value of pharmacy to stakeholders and promote the future of pharmacy practice and elevate the level of patient care.” On a national level, Clark notes, “Our work in the PSPC over the past 4 years has contributed to the National Performance Story published by the collaborative (see http://www.healthcarecommunities.org/showcontent.aspx?id=4294969160). This report details the impact that integrated medication management can have on patient outcomes.” The collaborative has partnered with a non-profit organization called The Alliance for Integrated Medication Management (AIMM) to expand and accelerate the work of the members (www.medsmatter.org).
Ongoing Developments that Support the Provision of MTM

Quality Measures, Incentives, and MTM Opportunities

Several initiatives are ongoing to define, assess, and improve the quality of pharmacy services, such as MTM, including those that affect Medicare Part D plans and ACOs. PQA has led several of these initiatives to develop and test pharmacy measures and to create report card systems for communicating performance on quality measures. In addition, some of the provisions and innovations in ACA are designed to improve quality of patient care. A number of these measures are likely to stimulate new opportunities for pharmacists to provide MTM by aligning financial incentives with performance.

CMS rates Medicare Part D plans on performance and quality using a star system, with 1 star as the lowest rating and 5 stars as the highest rating. This information is available to beneficiaries in the Medicare Prescription Drug Plan Finder to help them make informed choices. Several factors are taken into account when determining the star rating, including customer service measures, beneficiary complaints, member experience with the plan, drug pricing, and patient safety. Within the patient safety section of the ratings, CMS considers factors that can be influenced by pharmacist provision of MTM services.

There are 17 individual measures of quality in the 2012 Part D ratings, several of which were based on work done by PQA. In addition to the star measures, “display measures” are not included in the plan ratings, but are used to facilitate quality improvement by the plans. “Completion Rate for Comprehensive Medication Review” will be a display quality measure for plans in 2013, in anticipation of becoming a star rating system measure in future years.

CMS’s evaluation of the quality of MTM programs is underway. In 2012, CMS began a 3-year demonstration project for Medicare Advantage Part D plans in which plans will receive quality bonus payments based on their star ratings. Furthermore, the CMS 2013 call letter, which provides guidance to Part D plans for the 2013 program year, states, “Sponsors are expected to have a process in place to measure, analyze, and report the outcomes of their MTM programs, whether or not goals of therapy have been reached; capture drug therapy recommendations and resolutions made as a result of the MTM recommendations; and to capture beneficiary satisfaction with MTM services, providers, and outcomes.

CMS has established 33 performance measures for ACOs, which include several that provide opportunities for pharmacists to contribute to ACOs for achievement of positive outcomes. For example, the quality measures have been established for:

- Medication reconciliation: after discharge from an inpatient facility.
- Influenza immunization.
- Pneumococcal vaccination.
- Adult weight screening and follow-up.
- Tobacco use assessment and tobacco cessation intervention.
- Diabetes composite scores for:
  - Hemoglobin A1C <8%.
  - Low-density lipoprotein (LDL) cholesterol <100 mg/dL.
  - Blood pressure <140/90 mm Hg.
  - Aspirin use.
- Hypertension: blood pressure control.
- Ischemic vascular disease: complete lipid profile and LDL cholesterol <100 mg/dL.
- Ischemic vascular disease: use of aspirin or another antithrombotic therapy.
- Heart failure: beta-blocker therapy for left ventricular systolic dysfunction.
- Coronary artery disease (CAD): drug therapy for lowering LDL cholesterol.
- CAD: angiotensin converting enzyme inhibitor or angiotensin receptor blocker therapy for patients with CAD and diabetes and/or left ventricular systolic dysfunction.

Pharmacists who contract with ACOs can help address medication use issues, improve medication management activities, improve coordination of care activities, and provide medication reconciliation. Additionally, pharmacists can play an important role working with ACOs to help increase quality measure performance. Thus, ACOs should have financial incentives to work with pharmacists.

Finally, the implementation of ACA, especially through the CMS Innovation Center, has created several financial incentives to reduce hospital readmissions rates. Pharmacist provision of MTM services in integrated care settings, transition of care services, or other MTM models may significantly reduce readmissions rates. For example, at Rush University Medical Center in Chicago, 30-day readmission rates were 32% without pharmacist-delivered MTM services; readmission rates were 13% with MTM services.

Standardizing the Process of Care

APhA and other members of the Joint Commission of Pharmacy Practitioners (JCPP) are working to develop a standardized process of care for pharmacists’ patient care services to include straightforward descriptions of services delivered by pharmacists and use of standardized terminology for services. These standardized
elements will make pharmacists’ services consistent, predictable, and measurable. Providers, patients, and payers will have a clear expectation of the activities performed for each service, which will in turn facilitate marketing, billing, and tracking of outcomes.27

APhA and other JCPP organizations will be seeking the input of the pharmacy community in 2013 in efforts to standardize processes of care.

Development of Electronic Health Records and Health Information Technology to Support MTM

One of the primary challenges facing pharmacists who use EHRs is that many EHR systems do not communicate with each other. However, advances in EHR system function are leading to increased connectivity and interoperability among EHR systems. These changes are transforming the practice of pharmacy, allowing diverse EHR systems to communicate and exchange information. The number of organizations implementing such systems is growing, and pharmacists today have increased opportunities to utilize EHRs to advance patient care and perform functions including documentation and billing.

The development of a standardized process of care will facilitate creation of EHRs that can readily capture and disseminate information regarding pharmacists’ patient care services. The Pharmacy HIT Collaborative is working to develop HIT solutions that will support the defined process of care. The goal is to create interoperable HIT systems that use industry standard coding (SNOMED CT, which makes medical terminology understandable to computers) for documenting care to promote information sharing, quality/outcomes reporting, and assessment.

Electronic structured documents built around the standardized process of care will permit information exchange between systems, facilitate creation of systems that can read contents of standardized electronic documents, and allow information to be added to appropriate places in a patient’s EHR. Improved EHR formats also will assist in the development of pharmacy-specific electronic structured documents.
Discussion

Many of the findings in the 2012 MTM environmental scan were consistent with findings from surveys conducted in prior years. Both providers and payers continue to implement MTM services by using the same pattern of strategies for identifying potential candidates for MTM, defining populations for MTM services, selecting which services typically are offered, standardizing activities, identifying disease areas of focus, and establishing payment mechanisms. In terms of challenges, MTM providers continued to list operational issues such as lack of third-party payment for MTM, inadequate time, difficulty billing, and low payment rates for MTM services.

It is clear that MTM providers are investing in MTM for reasons such as practice improvement, satisfaction, and long-term gains rather than ROI in the short term. In 2012, only 30% of providers who were able to provide a response about their ROI reported an ROI greater than 1:1, suggesting a need for improved efficiency of service delivery. In some areas, there could be a need for more patients to justify investment in developing the service. Even with this result, 83% of MTM providers reported that their investment in MTM was worthwhile.

Despite these challenges, findings from our 2012 survey suggest that MTM is on a growth curve. The environmental scan found that 70% of MTM providers had more patients receiving MTM services in 2012, compared with 2010. For providers who were able to answer our question about the number of contract opportunities available in 2013, 34% reported that they expected an increase, 59% expected about the same number, and only 7% expected a decrease. Providers reported that the most common modifications to their MTM programs were enhanced MTM program offerings to beneficiaries and increased in-house provider staff.

The most significant challenge reported by MTM payers continues to be that patients are not interested or decline to participate in MTM service offerings. In 2012, MTM payers still had logistical challenges related to: raising consumer awareness of MTM, engaging patients in the service, enrolling members and getting them to participate in MTM programs, achieving scalability for MTM programs, and conducting outcomes assessment. Providers and payers report that direct contact with patients is their most successful marketing strategy. Building patient relationships will be vital for future MTM expansion and growth.

The 2012 survey included questions about the incorporation of MTM providers in emerging interdisciplinary team-based models of care such as ACOs and medical home practices. The findings showed that MTM providers are performing a variety of functions, such as MTM services, medication adherence services, patient education, disease state management, and transitions of care services. They are also working to improve performance on quality measures such as CMR completion rates, Beers criteria, PQA measures, and CMS star ratings.

Other published data have demonstrated the value of pharmacists in medical homes. Kucukarslan and colleagues reviewed randomized controlled trials between 1989 and 2009 that evaluated MTM programs in primary care medical homes; their resulting review reported on eight articles about the effect of MTM services on patient outcomes. The authors concluded, “Two service elements that benefit patient care were identified: (1) selecting patients with specific therapeutic problems and (2) implementing MTM services that involve timely communication with primary care providers to discuss therapeutic problems, along with routine patient follow-up to support medication adherence to changes in therapy.”

Another recent study of team-based MTM delivered in an integrated health system over 13 years found significantly lower costs and improved quality for clinics using MTM. The authors concluded, “Team-based care helped to achieve quality performance and control spending growth through [MTM] in a patient-centered medical home.”

These findings along with other developments for the provision for MTM, such as expanding opportunities created by ACA, indicate that MTM services will continue to evolve in coming years. As programs mature, systems for measuring their effects on outcomes are expected to further increase their sophistication. Greater use of EHRs will facilitate outcomes monitoring with the prospect of increasing efficiency and effectiveness of MTM services. Practice models that better align financial incentives with quality of care also are expected to stimulate growth of pharmacists’ patient care services and are more likely to result in financially sustainable practices.
References
