Medication therapy management (MTM) is a distinct group of services focused on optimizing medication-related therapeutic outcomes for individual patients; these services are independent of, but can occur with, the provision of a medication product. With the passage of the Medicare Prescription Drug Improvement, and Modernization Act of 2003, which mandated providing MTM program (MTMP) services to a targeted group of Medicare Part D and Medicare Advantage beneficiaries, new opportunities arose for enhanced access to medication-related services. However, a majority of Americans are not covered by Medicare or do not meet the criteria for MTMP services, and thus may be unable to experience the health benefits of Medicare-covered MTMP services.

Outside of the Medicare statute, the term MTM is intended to cover a broad range of programs that address medication use in public and private sectors. Successful experiences with MTM over the past decade have shed light on ways in which to expand program scope. With health care policy and reform possibly moving towards universal coverage, MTM models can be designed based on past successes, as well as new opportunities identified beyond targeted Medicare beneficiaries. One such area of opportunity is pediatric behavioral health.

Common services offered by MTM programs include comprehensive medication therapy review, compilation of patient medication lists, individualized medication education mailings, telephonic or face-to-face pharmacotherapy consultations, designing medication action plans to address specific drug therapy needs with patients, and communicating with physician prescribers and other health providers. MTM eligibility criteria specified by the Centers for Medicare and Medicaid Services (CMS) include multiple chronic conditions, multiple Part D medications, and anticipated Part D medication costs greater than a specified amount ($4,000 per year in 2007). However, these services and eligibility criteria do not nearly cover the scope of need for patient access, service type, utilization of pharmacist expertise and provider recognition that could more fully optimize medication-related outcomes in a pediatric behavioral health population.

We undertook an exploratory investigation, using a convenience sample, to assess how the lessons learned in MTM evaluations to date might be applied in a pediatric population receiving behavioral health services.

Lessons Learned in MTM Program Experience

Barnett et al. (2009) found that MTM services in community pharmacies evolved over 7 years (2000-2007) from patient education on acute medications to consultations with prescribers on chronic medication therapies. Some studies have shown positive benefit from MTM provided in specialty practice settings. Success has also been reported where MTM included pharmacist management of medication side effects and adverse drug reactions, and the tailoring of medication regimens to accommodate patient-specific needs. Meyer et al. observed that pharmacists can improve drug therapy by effectively identifying and addressing potential and actual medication-related problems (MRPs). MRP identification and the application of tested MTM strategies can potentially help maintain optimal drug therapy for any individual.

Cost minimization of prescribed medications is one goal of drug therapy optimization, but MTM encompasses a broad range of services and there are apparent opportunities for specialists including board-certified pharmacists for pharmacotherapy management. Most states permit some form of pharmacist-physician collaborative practice, but it seems that a greater proportion of MTM programs could still evolve to include collaborative practice or specific pharmacist prescribing arrangements to tailor medication regimens to patient-specific medication action plans.

Assessment of the Potential for MTM in Pediatric Behavioral Health

We performed a retrospective and exploratory chart review, based on a convenience sample, to assess the need for medication-related services in a primarily child and adolescent, non-Medicare population served by a private, ambulatory behavioral center providing primarily outpatient psychiatry, psychotherapy, and partial hospitalization services. We (a) collected demographic data; (b) defined eligibility for a potential MTM program for this patient population based on criteria that were derived from CMS, facility stakeholders, and pharmacist specialists; and (c) identified existing aspects of sound MTM that could potentially be applied to the sample. CMS criteria were adapted to define eligibility for MTM: (a) the presence of at least 1 psychiatric (Axis I) and 1 nonpsychiatric medical condition (Axis III) as the minimal criterion for the existence of multiple chronic conditions, and (b) multiple medications (4 or more, in this instance). Facility stakeholders had particular concern for monitoring medications consistent with Joint Commission medication management standards for behavioral health. From this position, additional criteria for patient selection were included: medications with potential for producing tardive dyskinesia and high-dose psychopharmacology (above recommended dosage ranges). Pharmacist specialist criteria were based on MRPs as categorized by routine drug regimen review and services. Potential needs as documented in the records were considered as part of fulfillment of the 3 principles of sound MTM: (a) need for medication management assistance, (b) availability of health professionals who intervene with patients and physicians to improve drug regimens, and (c) established performance outcomes measures.

From an average population of 600 patients served per month, a convenience sample of 60 (10%) was identified and assessed as potential candidates over a 6-week service period in February and March 2008. Data were collected from the patients’ medical records, including age, gender, Axis I (psychiatric) and Axis III
as a problem to monitor in outpatient practices. The medicalally taking and those that are documented has been recognized as absent. Discrepancy between the medications patients are actually taking and those that are documented has been recognized as a problem to monitor in outpatient practices. The medical charts in the sample provided no evidence of a comprehensive medication therapy review including assessment of prescription and nonprescription medications, herbal products and dietary supplements, a service that would have been provided by a pharmacist developing a medication action plan in an MTM program. When queried, clinic staff indicated that they believed that medications would be screened for drug interactions at the local pharmacy where patients’ prescriptions were filled and that they expected to be notified if there was a problem.

Medication lists were present in all of the charts; however, an Axis III condition for example, might be listed in the multiaxial diagnosis, but the medications used to treat the condition were absent. Discrepancy between the medications patients are actually taking and those that are documented has been recognized as a problem to monitor in outpatient practices.

The number and proportion of subjects meeting MTM selection criteria were 14 (25.9%) with at least 2 psychiatric diagnoses, 39 (72.2%) with at least 1 psychiatric and 1 other medical diagnosis, and 37 (68.5%) taking medications with tardive dyskinesia potential or high-dose psychopharmacology.

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