Medication Therapy Management
Versus Drug Regimen Review

The article by Horning, Hoehns, and Doucette in this issue of JMCP provides important information that should be of much interest to pharmacists and policy decision makers. The authors evaluate the quality of care under different forms of pharmacist services in long-term-care facilities (LTCFs). The federally mandated requirement for drug regimen reviews (DRRs) by pharmacists in LTCFs has long represented a good opportunity to broaden pharmacy’s role to ensure safe drug use, the cost-efficient use of resources, and optimum health outcomes. However, there remains a need for direct funding for the provision of pharmacists’ services in LTCFs, as well as changes in other factors, to facilitate pharmacists’ ability to optimize pharmaceutical care for LTCF residents.

The Medicare Modernization Act (MMA) of 2003 included a requirement that Medicare Part D sponsors provide a medication therapy management (MTM) program as part of their Medicare drug benefit program offered to Medicare beneficiaries. Recently, the promise of MTM programs has received much attention as an evolution in pharmacy services. MTM programs are designed to enhance enrollee understanding of medications and compliance with medication therapy as well as to detect adverse drug events and patterns of overuse or underuse of medications.

From a clinical perspective, there is a great deal of overlap between MTM services and DRR. A DRR is required for all LTCF residents monthly. The DRR conducted by the pharmacist in the facility setting is the financial responsibility of the nursing facility. On the other hand, MTM services apply only to targeted beneficiaries, the definition of which will be different from one prescription drug plan (PDP) to another. MTM services under Medicare Part D are the financial responsibility of the PDP, which receives compensation for these services as part of the administrative overhead provided by the Center for Medicare & Medicaid Services (CMS). It is likely that a majority of nursing facility residents will meet the criteria for a targeted beneficiary. However, many of the clinical services provided by pharmacists in the LTCF as part of DRR could be considered MTM services in the ambulatory setting. The primary factors to consider in distinguishing between MTM services and DRR are the facility setting and payment.

CMS provided no specific guidelines on the frequency or intensity of MTM services, and various PDPs may take a variety of approaches to providing them. A pharmacy service paid for by one PDP might not be covered by another PDP. Or, a pharmacist may have an agreement with one PDP to provide MTM services but may not have an agreement with another PDP in the same region, leading to a confusing variety of services for Medicare beneficiaries residing in the same LTCF. In addition, some PDPs may use their own staff pharmacists or nurses to provide remote services for targeted LTCF residents. However, LTCF residents are different from ambulatory Medicare beneficiaries in terms of regulatory and operational differences in the environment of care and prevalence of comorbid conditions and cognitive impairment.

Therefore, the American Society of Consultant Pharmacists believes that face-to-face interaction between a pharmacist with geriatric expertise and the LTCF staff, as well as with residents and caregivers, would be expected to provide the best outcomes. Further, a joint document from AARP, the Academy of Managed Care Pharmacy, American College of Clinical Pharmacy, American Geriatrics Society, American Pharmacists Association, American Society of Consultant Pharmacists, Case Management Society of America, College of Psychiatric and Neurologic Pharmacists, and Department of Veterans Affairs calls for the measurement of outcomes to document the quality and value of the pharmacist services provided. These organizations declare that MTM programs will need to identify and perform a variety of measurements and document program results to determine overall program effectiveness and achievement of desired treatment outcomes (economic, clinical, or humanistic).

Few standards exist for determining the quality of pharmacy services, specifically in LTCFs. Horning, Hoehns, and Doucette evaluated the quality of care by looking at various process measures from LTCFs in which the residents received intensive consulting services from pharmacists compared with LTCFs receiving traditional DRR pharmacy services. They made comparisons with various clinical practice guidelines as the basis for evaluating care quality. Under Medicare Part D and MTM, we can expect to see more studies of this nature in the future.

Section 109(b) of MMA amended Section 1154(a) of the Social Security Act to give quality improvement organizations (QIOs) authority to provide quality improvement assistance pertaining to prescription drug therapy to Medicare Advantage plans and to prescription drug sponsors offering PDPs. QIOs are independent, mostly nonprofit health care organizations that employ physicians from a wide range of specialties, statisticians, epidemiologists, health information technology experts, nurses, communications professionals, pharmacists, and other health care specialists who serve as a resource for local health care professionals and consumers.

Under the direction of CMS, the QIO program consists of a national network of 53 QIOs responsible for each U.S. state, territory, and the District of Columbia. The main goal of QIOs is to accelerate the diffusion of evidence-based medicine into everyday clinical practice. With implementation by QIOs, Section 646 demonstration projects test system changes to improve the quality of care while increasing efficiency across the whole system. According to the Quality Improvement Organization Support Center for Pharmacy, there are 5 projects under way focused on pharmacotherapy in LTCF settings. CMS intends to use these demonstration projects to identify, develop,
and disseminate major multifaceted improvements to the entire health care system. In addition, CMS believes that these efforts will identify best practices that will evolve into industry practice standards and could eventually be adopted as federal standards. For additional information on QIO efforts in pharmacy, those interested should contact their own state’s QIO.13

This work by Horning, Hoehns, and Doucette is laudable. The interpretation of this work is limited because it is a self-assessment, leaving the potential for bias. Perhaps in the future, Medicare QIOs will provide an independent source of data collection and evaluation of such projects so that CMS can obtain unbiased estimates of the outcomes of more intensive pharmacists’ services in LTCFs. Pharmacists and policymakers alike should pay close attention to this and other research on pharmacotherapy in LTCFs as health care delivery continues to evolve to improve the care for those most in need of pharmacists’ clinical services.

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DISCLOSURES
The author discloses that he serves as pharmacy consultant for the LTCF pharmacy collaborative project by the Medicare QIOs in Indiana (Health Care Excel), Kentucky (Health Care Excel), and Ohio (KePRO).

REFERENCES


