

## **Welcome to the Community Care Family Care Partnership Program (HMO SNP)(Community Care) Medication Therapy Management Web Page**

Some members who have several complex medical conditions may need to take many drugs at the same time or have very high drug costs. The Medication Therapy Management (MTM) program can help members in these situations. This is a free and voluntary service for eligible members and is not considered a benefit.

The goal of the Medication Therapy Management program is to be sure members are using the drugs that will treat their medical conditions best and are getting the desired results from their medications. The MTM program also tries to reduce medication problems that may occur. Community Care is pleased to work with the Centers for Medicare & Medicaid Services (CMS) to provide this program to eligible members.

### **Who is eligible for the Medication Therapy Management Program?**

A member must meet all of the following criteria to be eligible for the program:

- Be a member of Community Care's Family Care Partnership Program (HMO SNP) (Community Care).
  - Be enrolled in Medicare Parts A, B and D.
  - Take a minimum of six (6) prescription drugs covered by Medicare Part D.
  - Have two (2) of the targeted diagnoses as documented in their electronic medical record on the Community Care system. The targeted diagnoses for 2021 are:
    - o Rheumatoid Arthritis
    - o Chronic Heart Failure (CHF)
    - o Dyslipidemia
    - o Asthma
    - o Bi-polar disorder.
  - Have Medicare Part D covered drug costs equal to or greater than \$1094 per calendar quarter.
- Members who meet the above criteria will automatically be enrolled in the 2021 MTM program. Members will be contacted by mail and/or telephone and informed of their enrollment in MTM. They will also be offered an opportunity to schedule an annual comprehensive medication review (CMR). This is a free and voluntary service for eligible members, so they may choose not to participate at that time.

### **What services are provided by the MTM Program?**

- Each quarter a pharmacist or other health professional will review the member's medications.
- The review will consider the following criteria:
  - Is the member taking appropriate medications for the targeted diagnoses?
  - Has laboratory testing been done to monitor for those diagnoses?
  - Is the member taking their prescribed drugs as assessed by how often they fill their prescriptions?
  - Are there possible significant drug to-drug interactions for the targeted diagnoses?
  - Are there are other drug concerns that should be looked at?
- An annual comprehensive medication review (CMR) will also be offered. The CMR is conducted by a pharmacist or other health professional and may be done in person or on the phone. It takes about 30 to 60 minutes to complete. A member may refuse this review.
- If the member agrees to the CMR, it will include the member's medications (prescription and non-prescription), an evaluation for a high number of medications (more than three (3) drugs used to treat the same condition and greater than or equal to fifteen (15) Medicare Part D medications) and an assessment for high risk medications identified on the Beer's Criteria 2019.
- A written summary of the completed CMR will be mailed to the member, including a list of current medications, issues discussed with the member and a plan for the member to address these issues. The summary will be written in a standardized way provided by Medicare.
- Therapy recommendations will be sent to the member's primary care physician or nurse practitioner for follow-up.

**A blank copy of the Personal Medication List is at the end of this document. For more information or to request MTM service documents, please contact:**

- Megan Farley-Snieg, Pharm D at (414)902-2527 or
- Dmitri Mayer, RPH at (414)231-4107
- Community Care Inc. Pharmacy; 1555 S Layton Blvd, Milwaukee, WI 53215  
Community Care is a Coordinated Care Plan with a Medicare Advantage contract and a contract with the Wisconsin Medicaid Program.

Enrollment with Community Care depends on contract renewal.

**MEDICATION ACTION PLAN FOR** < *Insert Member's name, DOB: mm/dd/yyyy* >

This action plan will help you get the best results from your medications if you:

1. Read “What we talked about.”
2. Take the steps listed in the “What I need to do” boxes.
3. Fill in “What I did and when I did it.”
4. Fill in “My follow-up plan” and “Questions I want to ask.”

Have this action plan with you when you talk with your doctors, pharmacists, and other healthcare providers in your care team. Share this with your family or caregivers too.

**DATE PREPARED:** < *INSERT DATE* >

<b>What we talked about:</b> < <i>Insert description of topic</i> >	
<b>What I need to do:</b> < <i>Insert recommendations for beneficiary activities</i> >	<b>What I did and when I did it:</b> < <i>Leave blank for beneficiary's notes</i> >

<b>What we talked about:</b>	
<b>What I need to do:</b>	<b>What I did and when I did it:</b>

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<b>What we talked about:</b>	
<b>What I need to do:</b>	<b>What I did and when I did it:</b>

<p><b>My follow-up plan</b> (add notes about next steps):</p> <p><i>&lt; Leave blank for beneficiary's notes &gt;</i></p>
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<p><b>Questions I want to ask</b> (include topics about medications or therapy):</p> <p><i>&lt; Leave blank for beneficiary's notes &gt;</i></p>
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**PERSONAL MEDICATION LIST FOR** < *Insert Member's name, DOB: mm/dd/yyyy* >

This medication list was made for you after we talked. We also used information from < *insert sources of information* >.

- Use blank rows to add new medications. Then fill in the dates you started using them.
- Cross out medications when you no longer use them. Then write the date and why you stopped using them.
- Ask your doctors, pharmacists, and other healthcare providers in your care team to update this list at every visit.

Keep this list up-to-date with:

- prescription medications
- over the counter drugs
- herbals
- vitamins
- minerals

If you go to the hospital or emergency room, take this list with you. Share this with your family or caregivers too.

**DATE PREPARED:** < *INSERT DATE* >

**Allergies or side effects:** < *Insert beneficiary's allergies and adverse drug reactions including the medications and their effects* >

<b>Medication:</b> <i>&lt; Insert generic name and brand name, strength, and dosage form for current/active medications. &gt;</i>	
<b>How I use it:</b> <i>&lt; Insert regimen, including strength, dose and frequency (e.g., 1 tablet (20 mg) by mouth daily), use of related devices and supplemental instructions as appropriate &gt;</i>	
<b>Why I use it:</b> <i>&lt; Insert indication or intended medical use &gt;</i>	<b>Prescriber:</b> <i>&lt; Insert prescriber's name &gt;</i>
<b>&lt; Insert other title(s) or delete this field &gt;:</b> <i>&lt; Use for optional product-related information, such as additional instructions, product image/identifiers, goals of therapy, pharmacy, etc., and change field title accordingly. This field may be expanded or divided. Delete this field if not used. &gt;</i>	
<b>Date I started using it:</b> <i>&lt; May be estimated by Plan or entered based upon beneficiary-reported data, or leave blank for beneficiary to enter start date &gt;</i>	<b>Date I stopped using it:</b> <i>&lt; Leave blank for beneficiary to enter stop date &gt;</i>
<b>Why I stopped using it:</b> <i>&lt; Leave blank for beneficiary's notes &gt;</i>	

**PERSONAL MEDICATION LIST FOR** < *Insert Member's name, DOB: mm/dd/yyyy* >

(Continued)

<b>Medication:</b>	
<b>How I use it:</b>	
<b>Why I use it:</b>	<b>Prescriber:</b>
< <i>Insert other title(s) or delete this field</i> >:	
<b>Date I started using it:</b>	<b>Date I stopped using it:</b>
<b>Why I stopped using it:</b>	

<b>Medication:</b>	
<b>How I use it:</b>	
<b>Why I use it:</b>	<b>Prescriber:</b>
< <i>Insert other title(s) or delete this field</i> >:	
<b>Date I started using it:</b>	<b>Date I stopped using it:</b>
<b>Why I stopped using it:</b>	

<b>Medication:</b>	
<b>How I use it:</b>	
<b>Why I use it:</b>	<b>Prescriber:</b>
< <i>Insert other title(s) or delete this field</i> >:	
<b>Date I started using it:</b>	<b>Date I stopped using it:</b>
<b>Why I stopped using it:</b>	

<b>Medication:</b>	
<b>How I use it:</b>	
<b>Why I use it:</b>	<b>Prescriber:</b>
< <i>Insert other title(s) or delete this field</i> >:	
<b>Date I started using it:</b>	<b>Date I stopped using it:</b>
<b>Why I stopped using it:</b>	



If you have any questions about your medication list, call < *insert MTM provider contact information, phone numbers, days/times, etc.* >.