Thinking Outside the Pillbox

Six Priorities for Action to Support Improved Patient Medication Adherence

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Background

NEHI conducted a series of policy roundtables on patient medication adherence in Washington in 2012 and consulted a wide range of adherence policy leaders early in 2013. This issue brief summarizes key insights from those conversations. The views expressed are NEHI's.

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Policymakers are giving increased attention to opportunities for improved medication adherence and their potential benefits, as evidenced by a range of recent reports. In June 2013, the IMS Institute released a report titled "Avoidable Costs in U.S. Healthcare: The $200 Billion Opportunity from Using Medicines More Responsibly," which found $105 billion annually in potentially avoidable costs due to medication nonadherence. A March 2013 analysis for the Medicare Payment Advisory Commission (MedPAC) reiterated that adherence rates vary among patients with different disease states and different demographic characteristics.

In November 2012, the Congressional Budget Office announced that henceforth it will assume that a 5 percent increase in the number of prescriptions used by Medicare patients will result in a 1 percent decrease in their medical and hospital spending. Finally, in September 2012, a detailed systematic review of adherence literature conducted for the Agency for Healthcare Research & Quality (AHRQ) found evidence of several promising adherence-specific interventions.

To these and other policymakers seeking to improve medication adherence, we offer six themes that emerged from a series of medication adherence roundtables held during 2012 by the national health policy institute NEHI.

1) Promote sharing of best practices and lessons learned from pilots of new medication management techniques

Participants in medication adherence forums held by NEHI and other organizations continue to express a strong desire to learn from organizations or partnerships that are succeeding in improving medication management. Frequently, innovative programs are not published in the peer reviewed literature in the rush to implement. Informal opportunities for discussion and sharing of lessons learned about medication management best practices will be crucial to speed the learning cycle from the work of health plans and provider groups.

2) *Support large-scale implementation of promising, evidence-based "tactics" for improved medication management*

A number of practices emerging in the published literature appear to be effective tactics for improving medication management. Examples of promising practices include: having nurses or pharmacists follow-up with patients after hospital discharge to verify that the correct medication regimen has been started; synchronization of medication refills for patients with multiple chronic medications; and the 'pharmacy home' model in which patients receive all their medications from one pharmacy, if not one pharmacist. Many of these promising tactics are best delivered in combination with each other and supported by enabling factors such as e-prescribing. In other words, the whole is likely greater than the sum of the parts.

Some progress is being made in adoption of these best practices. For example, to support refill synchronization, the Medicare program will require Part D plans to apply a daily cost-sharing rate to certain prescriptions dispensed by a pharmacy for a less than 30-day supply starting January 1, 2014. The daily cost-sharing rate will reduce patient costs when synchronizing their medications. In addition, the Pharmacy Quality Alliance is currently testing a new measure for primary adherence/first-fill that utilizes data from electronic prescribing systems.

3) *Continue development of metrics of medication use that will spur adoption of proven medication management strategies*

Pharmacy Quality Alliance metrics of adherence to diabetes, cholesterol-lowering and hypertension drugs now have significant weight in determining the current Star Ratings for Medicare Part D prescription drug plans. Early results suggest that the Star Ratings are driving adherence promotion by the Medicare plans and pharmacies in their networks. These metrics serve as a proxy for patient behavior by tracking the percentage of targeted patients with 80 percent or higher Proportion of Days Covered (PDC).[i] Decisions on how to raise patient PDC rates are largely left up to Medicare drug plans, associated Pharmacy Benefit Managers (PBMs) and network pharmacies, although they must meet Medicare guidelines on the provision of Medication Therapy Management to eligible patients.

4) *Support continued rapid adoption of electronic prescribing and electronic medical records with capabilities that support evidence-based interventions for improved adherence*

Near universal use of electronic prescribing, electronic medical records, and electronic patient medication data exchange is a key component of improving patient medication adherence. The more providers adopt these capabilities, the more easily the health care system will be able to coordinate medication management and care for the chronically ill.

Adoption of electronic prescribing (e-prescribing) has been very rapid in recent years. Surescripts, the national e-prescribing network, reports that 44 percent of prescriptions written in 2012 were delivered to the pharmacy electronically, a 38 percent increase over 2011. Surescripts also reports that 87 percent of electronic prescriptions were written from an Electronic Medical Record (EMR), as opposed to a standalone electronic prescribing program. Small physician practices are starting to catch up with large physician practices in their adoption of electronic prescribing, and internists surpassed all other medical specialists for use of e-prescribing.[ii] All this suggests that a foundation has been laid for tighter medication management for chronic disease patients, including the ability to coordinate medication use among prescribing physicians, pharmacists, and other professionals such as nurses and nurse case managers.

The objective now must be for prescribers to use electronic prescribing data to coordinate medication use. Notwithstanding the upsurge in e-prescribing and EMR adoption, recent data suggest that the physician community has far to go toward meaningful use of the electronic health record capabilities designed to support safe prescribing, patient education, medication optimization, and coordination among disparate health care providers. Data published in the *New England Journal of Medicine* suggest that only about 18 percent of primary care providers in the U.S. were utilizing EMRs at a Stage 1 Meaningful Use level by mid-year 2012.[iii] Stage 1 and Stage 2 capabilities include essential functions, such as the capability to assemble active patient medication lists. A more truly comprehensive set of medication management capabilities could be adopted in the forthcoming Stage 3, as was recently suggested by a broad coalition of adherence proponents.[iv] These would include capabilities for refill synchronization, routine medication reconciliation, routine patient reminders, patient education, accurate fill and refill data, and tracking of adherence performance. Implementation of the Meaningful Use criteria should also promote interoperability of medical records, and the exchange of patient data not only among physicians but among physicians and pharmacists.

5) Continue to improve Medication Therapy Management services in Medicare Part D including improvements in program services and targeting; consider wider adoption of medication management by other health care payers

The Medicare Modernization Act required all Part D and Medicare Advantage plans to offer Medication Therapy Management (MTM) to eligible beneficiaries to ensure optimum therapeutic outcomes through improved medicine use, and to reduce the risk of adverse events.[v] Despite the mandate for plans to offer MTM, the type and quality of services offered varies widely, and many beneficiaries who might benefit from MTM are not eligible to receive services. In an effort to improve the program, reforms included in the Affordable Care Act created standard formats for communication with patients. In its recent Call Letter, CMS actively encouraged Part D and Medicare Advantage plans to expand eligibility for MTM services as of 2014. Medicare Advantage and Medicare Part D plans have further incentive to offer MTM services to beneficiaries as a means of improving their Star Ratings performance. MTM vendors and MTM service networks have expanded to meet additional demand and program capacity. It appears

that MTM services are in a period of transition and should be carefully watched to determine if recent changes will lead to improvements or if further changes are needed.

As the Medicare MTM program continues to improve, other payers including Medicaid, employers and commercial health plans should consider whether to offer medication management services. Health plans and employers managing the full range of health benefits may be in a better position to offer more comprehensive medication management services (see NEHI Issue Brief, "Improving Patient Medication Adherence: Key Issues and Challenges in the Daily Practice of Medicine, "January 2013).

6) *Integrate medication adherence research, policy development and advocacy with broader efforts that aim to improve use of medicines, including those focused on patient safety*

Stakeholders agree that good medication practices should simultaneously reduce waste, avoid medication errors and support medication adherence. However, provider improvement programs and health care policy frequently treat medication-related goals in separate siloes. For example, adverse drug events, medication errors, and poor patient medication adherence are frequently addressed as separate problems, despite the fact that providers address these issues through common systems and common protocols – or should. Going forward, stakeholders need to address these problems through a common strategy or vision of improved medication use.

Conclusion

There are many reasons to be optimistic that patient medication adherence can be improved in the U.S. The introduction of adherence metrics to the Medicare Part D Star Ratings; the responses of Part D plans and pharmacy networks; improvements to the Medicare Medication Therapy Management benefit under the Affordable Care Act; growing use of electronic prescribing and electronic medical records: these and other factors suggest that real change is on the horizon. Proponents of better patient adherence should rally behind a comprehensive vision of good medication use that encompasses interventions to promote adherence, and promote a vigorous agenda for policy change that will create incentives for proven adherence interventions.

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[i] PDC is calculated from prescription drug claims. If the claims show that the patient(s) had medications available at 80 percent or more of the period in question, they would meet the 80 percent PDC threshold.

[ii] See Surescripts National Progress Report 2012 at http://www.surescripts.com/about-e-prescribing/progress-reports/national-progress-reports#downloads

[iii] Adam Wright et al, Letter to the Editor: Early Results of the Meaningful Use Program for Electronic Health Records, New England Journal of Medicine, February 21, 2013 pp779-780

[iv] See comment letter to the Office of the National Coordination from the Coalition for Affordable Health Care Coverage, the AARDEX Group, CVS Caremark, LTCPCMS, Merck, Mirixa, MWV Healthcare, the National Association of Chain Drug Stores, the National Consumers League, the National Council for Community Behavioral Healthcare,

the National Council on Patient Information and Education, and the Pharmacy Quality Alliance, January 14, 2013 accessed at http://cahc.net/wp-content/uploads/2013/01/HITPC_comment_letter-FINAL.pdf

[v] CMS Website: Medication Therapy Management. http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html.