NATIONAL PACE ASSOCIATION
Support. Innovate. Lead.

"Drugs don't work in patients who don't take them"

(C. Everett Koop, MD, US Surgeon General, 1985)

MANAGING ADHERENCE ISSUES WITHIN A PACE ORGANIZATION

BACKGROUND

- The term medication adherence is defined as the extent to which a person's medication-taking behavior coincides with the clinical prescription.
- Adherence is a crucial component to the treatment of chronic diseases and maximizing therapeutic outcomes.
- Adherence to prescribed medications represents a complex series of decisions and behaviors, and optimal adherence involves several necessary components. This process has been described in three phases:
  1. Initiation: healthcare providers must prescribe a medication and clearly communicate its utility and appropriate use to the patient and family, and patients must then fill the prescription;
  2. Implementation: patients must then take the prescribed medication according to directions; and
  3. Discontinuation: patients continue use as long as indicated, without premature termination.

Adherence vs. compliance.[1] Adherence is defined as a mutually agreed upon plan between a patient and clinician that patients can follow with a clinicians support. Compliance is a unilateral decision denoting the expectation that if a medication is prescribed, the patient should take it.

GENERAL BEST PRACTICES

1. Focus on communication. When clinicians and patients establish and maintain ongoing, effective communication throughout a treatment regimen, the risk of deviation — whether intentional or not — declines.

2. Deliver education. Providing ongoing education about treatment — including its purpose, expected timeframe, potential issues, and ways to improve success — can help motivate patients to follow and stay committed to their regimen.

3. Share resources. Clinicians and organizations should supplement their communication and education efforts by giving and recommending resources to help with treatment adherence. These can include brochures and pamphlets, mobile apps, and videos.

4. Provide easily accessible assistance. Many patients will have questions and concerns about and their treatment throughout the course. The faster these questions and concerns are addressed, the more likely it is that patients will not deviate from their regimen.

5. **Treat all patients uniquely.** Considering the wide range of potential obstacles to treatment adherence, do not make assumptions about patients and their ability to adhere with a treatment regimen. Approach each patient with a clean slate. A blanket approach is likely to result in missed opportunities to address challenges effectively.

6. **Don't go it alone.** Efforts to improve treatment adherence and compliance are most successful when all stakeholders are involved and work together: patients/family members, primary care physicians, specialists, nurses, pharmacists, and therapists. Improving collaboration and coordination will have a positive impact on treatment adherence.

PACE organizations are at the forefront of patient care to address these concerns as they function as both the insurance payer and provider through an interdisciplinary team.

FACTORS INVOLVED IN PATIENT NON-ADHERENCE

- Reasons for non-adherence can be broadly classified: patient, health care provider, socioeconomic, and healthcare system factors (Table 1).

Patient Factors	Health Care Provider Factors
Complex drug regimens/polypharmacy Poor labeling instructions Lack of medication organization Difficulty opening containers Lack of perceived benefit Cultural factors & medication beliefs Untimely refills/frequent pharmacy trips Lack of healthcare insurance coverage	Poor communication Lack of time to spend with patients Lack of follow-up Lack of goals-of-care alignment
Socioeconomic Factors	**Health Care System Medication Factors**
Lack of caregiver support Large caregiver burden	Lack of patient education

Table 1. Factors that contribute to non-adherence.

- Elderly patients in general are prone to diagnosis with multiple chronic conditions, which increases the risk of polypharmacy and non-adherence. The results of these include decreased treatment outcomes, more frequent hospital or physician visits, and possible overtreatment of a condition.

ADHERENCE TACTICS

- Use of medi-set boxes or medicine-on-time, blister packs, med reminders, MD2 machines.
- Insulin:
  1. Pump devices;
  2. Pre-filled pen needle in med box; and,

3. Use of long-acting formulations.

- Other tactics may include switching medications to once-daily administration by use of long-acting formulations, switching to medications with no timing limitations (i.e. may be taken at any time of day), reducing pill burden by use of combination products, or use of injectable depot-formulations.
- For commonly abused medication (i.e., opioids or benzodiazepines) using therapy agreements can provide adherence support.

COUNSELING APPROACHES

- Clinicians should consider meeting with patients regularly when medication non-adherence may be suspected.
- Clinicians should focus on meeting the patient where they are and use open-ended questions to discuss the patient's thoughts, beliefs, and feelings around medications (Figure 1). This will help determine potential barriers in a non-threatening, non-judgmental way. It may also allow the clinician to see that a patient may prefer an alternative treatment approach.
- Encourage patients to keep their medication in cool, dry places where it cannot be avoided, but make sure it is always out of the reach of children or pets. Consider uniform recommendations on where to store medications. This standardization can help locate them easily in an emergency.
- Encourage patients to set an alarm clock or phone alarm to remind them when to take their medications.

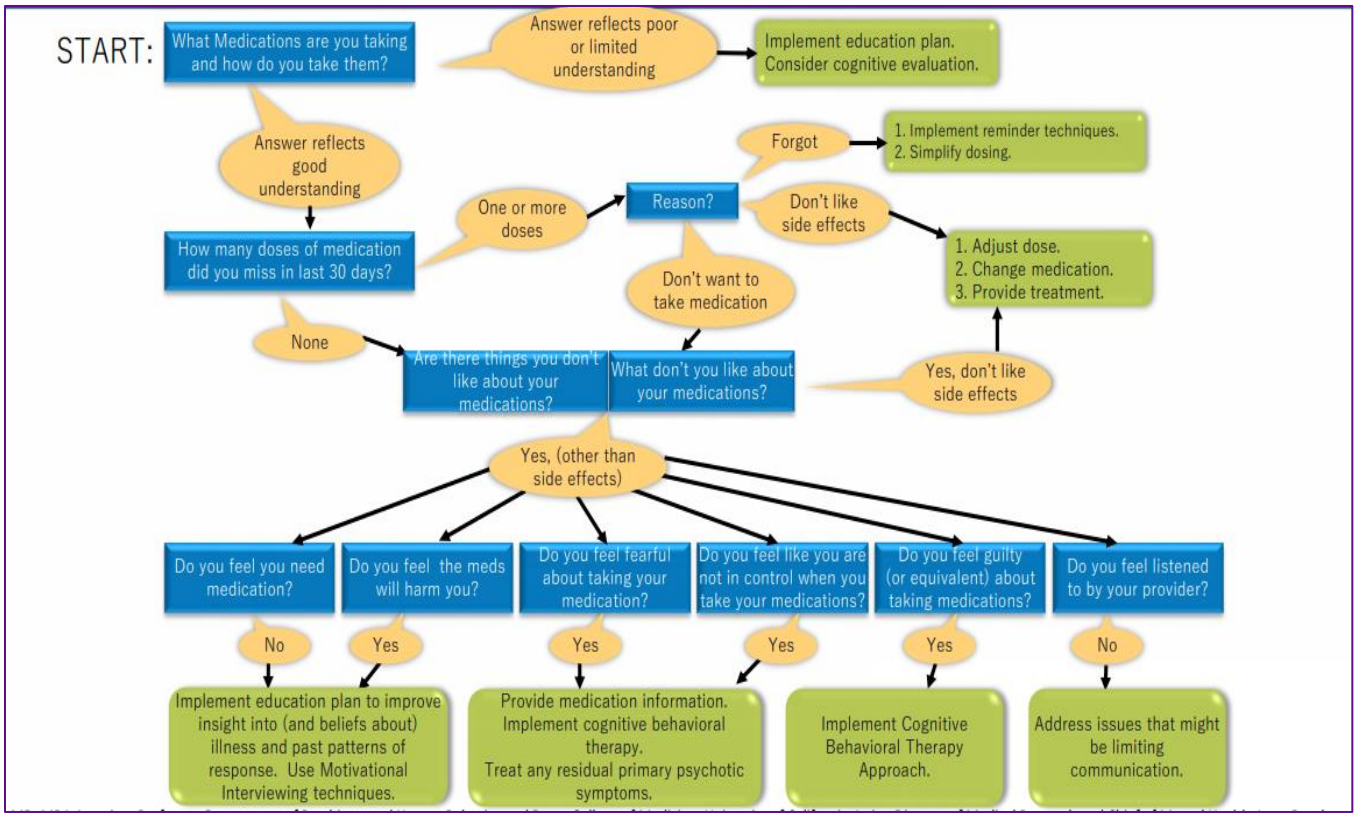

Figure 1. Medication Adherence Algorithm

DEPRESCRIBING TACTICS

Non-clinical Approach

- PBM and Acumen reports may be utilized to identify over-utilization targets.
- Homecare nurse assessment of stock supplies and medication adherence.
- Ensure any medications prescribed or administered by specialists are confirmed and documented in the internal electronic health record to avoid duplication.
- Avatar programs to assist patients throughout the day.

Clinical Approach

- Use of the VIONE program (Figure 2).[2]

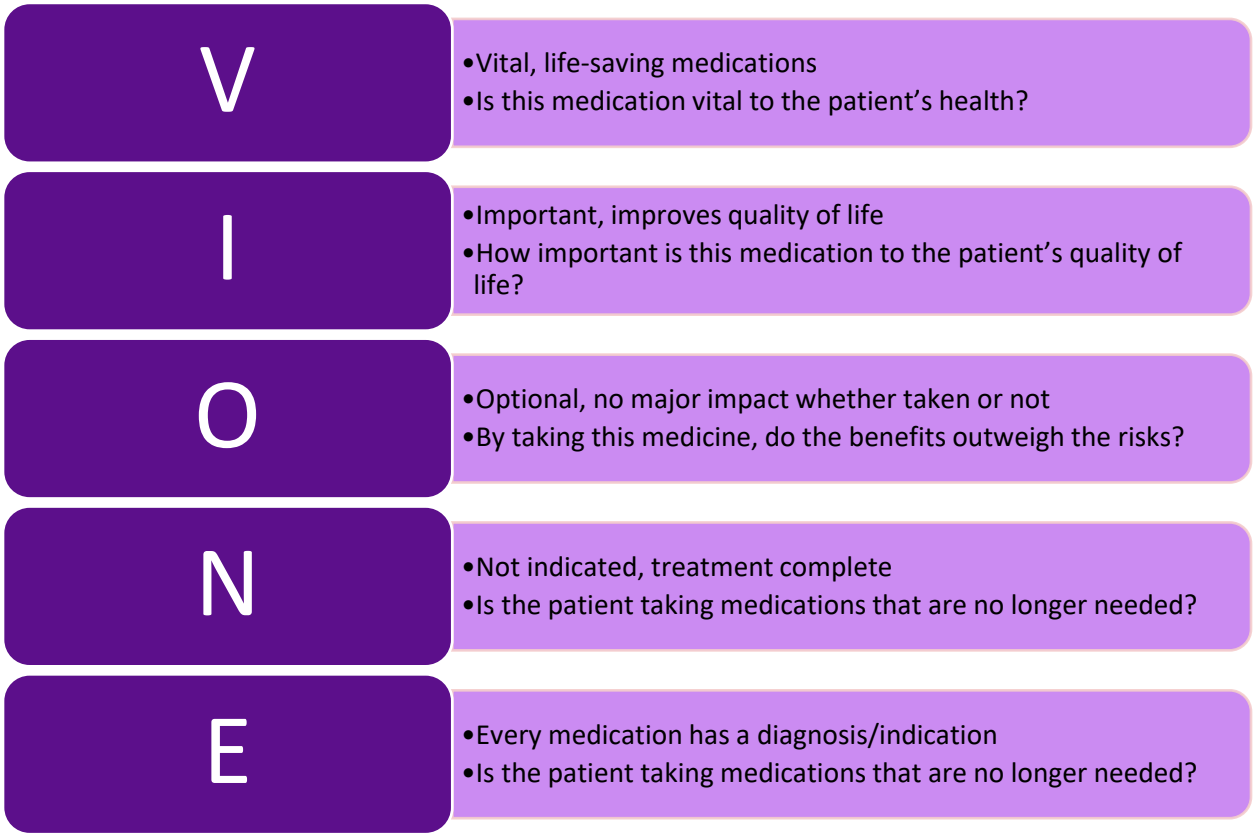

Figure 2. VIONE Program.

- Establish acceptable adherence levels (i.e., 80%) for the organization (Figure 2).

$$percent\ adherence = 100\ x \left(\frac{\#\ of\ prescription\ fills\ in\ a\ period\ of\ time}{total\ \#\ of\ prescriptions} \right)$$

Figure 3. Sample Adherence Calculation.

- Incorporation of the STOPP/START criteria, BEERS Criteria®, and anticholinergic burden into all internal medication reviews and subsequent documentation.[3,4]
- Deprescribe medications as clinically appropriate to reduce pill burden.
- Include stop dates for acute treatment orders or time-limited courses (e.g., antiviral, antibiotic, anticoagulants for DVT/PE).

Patient Approach

- Use of directly observed therapy (DOT) for treatments where efficacy is essential (e.g. tuberculosis, hepatitis C virus, human immunodeficiency virus).
- Therapeutic drug-level monitoring or random urine drug screens.
- Indirect methods such as patient questionnaires, patient self-reports/diaries, pill counts, evaluation of laboratory parameters for clinical response.

SPECIAL POPULATIONS

Dialysis

- Medicare Part B covers dialysis services furnished on an outpatient basis in Medicare-certified end-stage renal disease (ESRD) facilities through facility-level adjusted prospective payment systems (PPS). Payment for select drugs and biologicals is included under this umbrella.
- Drugs and biologicals always considered to be part of renal dialysis services are those used for access, anemia, bone and mineral metabolism, and cellular management. Other categories of drugs included in the ESRD PPS base rate may be for the treatment of side effects related to dialysis, including: anti-emetics, anti-infectives, anti-pruritics, anxiolytics, fluid management, antibiotics used for the treatment of access infections, or medications used for vascular access procedures.
- ESRD facilities are responsible for furnishing these drugs directly to patients or through alternative arrangement. Collaboration with the dialysis facility by a point person in the PACE organization and careful documentation is critical to ensure coordinated care and adherence.

Palliative Care

- Mutual understanding of the patient's goals of care.
- Establish and discuss time-horizon-to-benefit for certain medications.
- Assess the need for primary prevention of certain medications.
- Discuss and implement tactics for gradual dose reductions of antipsychotics, especially in consideration of comorbidities and monitoring burden.
- Recognize and discuss the risk vs. benefit of immunizations at end of life, taking into consideration efficacy, safety and goals of care.

Opioids

- Treatment plan adherence is critical to decreasing the rate of opioid use disorder (OUD) and reducing deaths. Effective areas of focus are overuse prevention, treatment access, and targeted intervention through regular data analysis.
- The CMS Opioid Strategy focuses on three key areas:
    1. Prevention: preventing and reducing OUD by promoting safe opioid prescribing and encouraging non-opioid pain treatments;
    2. Treatment: increasing access to evidence-based treatment for OUD; and,
    3. Data: leveraging data to target prevention and treatment efforts and to support fraud, waste, and abuse detection.[5]
- All PACE programs should have established policies and procedures that address opioid utilization, including evaluation of these procedures for efficacy.
- PACE organizations can consider the use of treatment agreements for additional adherence support.

REFERENCES

1. Ross, S. Key differences between treatment adherence vs. compliance. https://blog.cureatr.com/key-differences-between-treatment-adherence-vs-compliance. Accessed March 12, 2020.
2. Battar S, Watson Dickerson KR, et al. Understanding principles of high reliability organizations through the eyes of VIONE, a clinical program to improve patient safety by deprescribing potentially inappropriate medications and reducing polypharmacy. *Fed Pract*. 2019 December;36(12):564-568.
3. 2019 American Geriatrics Society Beers Criteria® Update Expert Panel. American Geriatrics Society 2019 Updated AGS Beers Criteria® for potentially inappropriate medication use in older adults. *J Am Geriatric Soc*. 2019 Apr; 67(4):674-694.
4. O'Mahony D, O'Sullivan D, et al. STOPP/START criteria for potentially inappropriate prescribing in older people: version 2. *Age Ageing*. 2015 Mar;44(2):213-218.
5. Centers for Medicare & Medication Services (CMS). Centers for Medicare & Medicaid Services (CMS) opioid misuse strategy 2016, January 5, 2017 [Available from: https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf]