Medication Adherence: Managing for Total Value

Presented by:

The Foundation for Managed Care Pharmacy
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There is no CME/CE credit awarded for this activity.

This presentation is for Purchasers and Payors of Prescription Drug Benefit Programs and Pharmacists practicing in a managed care setting. The objective is to provide information about improving medication adherence by understanding the impact of poor adherence, the drivers, and strategies to improve.

This presentation was developed by the Foundation of Managed Care Pharmacy Education Committee.

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Medication Adherence:  
* Managing for Total Value*

- What is the Foundation for Managed Care Pharmacy (FMCP)?
- What is medication adherence?
- Why should I care about medication adherence?
- What can be done to increase medication adherence?

• Overview of FMCP and what we do  
• What is adherence- address the terminology & some reasons people don’t take their medications  
• Why should a plan sponsor care about medication adherence? We will discuss the impact of adherence on the health of your work force as well as the impact of poor adherence on your overall healthcare and productivity spend  
• What can a plan sponsor do? we will discuss what you need to know about adherence within your membership, what you need to know to evaluate the solutions that are appropriate for your program and some solutions being developed and implemented by others
FMCP’s Passion

• Dedicated to helping people get the medications they need through the use of their pharmacy benefit, leading to healthier, happier lives

FMCP’s Value Proposition

• A national 501(c)(3) organization supporting the Academy of Managed Care Pharmacy (AMCP)

• Unbiased, credible source of information that can be utilized by consumers, payers, providers of pharmacy benefits, and providers of care to obtain needed medications through the pharmacy benefit

• Research and education efforts assists consumers, payers, and health care professionals in staying current, as well as educate public policymakers

• Ability to pool resources and partner with those who care about helping people receive the medications they need in order to ensure research and education efforts continue
Examples of FMCP’s Contributions

• Specialty pharmacy initiative
  – Eight key stakeholder interviews

• Value-based health care: role of pharmaceuticals
  – Strategic leadership forum

• Health care leadership
  – Training and supporting managed care pharmacy health care leaders of the future

www.fmcpnet.org
Use this slide to engage the audience in identifying why FMCP has identified medication adherence as such an important issue.
• This example shows how there are several places in a patient's therapy where the care plan outlined by the physician (in this case the prescription for medication) can break down.

• Walk through Q & A asking for audience response.

• 50-70 rx's are never filled after the original prescription is written. This is called primary. Hard to capture and intervene because most systems don’t know the physician wrote an rx until after the initial fill. Study that was available in Feb 2010 reviewed e-prescribing data and found 28% of new meds were not filled. (Primary Medication Non-Adherence: Analysis of 1915,930 Electronic Prescriptions: J Gen Intern Med)

• Of those 50-70 rx's how many are picked up by the patient? 48-66

• Of those how many are taken according to the physician's instruction? 25-30 Non-adherence is not only forgetting or not taking your meds at all, it is not taking the medication as prescribed

• Finally, how many patients will get their medication refilled so they can continue therapy after the initial supply? 15-20

• Explain that the numbers we show are in ranges…. Non-adherence rates will be specific to given population based on many factors such as demographics, benefit design, socio-economic status, etc. We will discuss further …
What Is Medication Adherence?

“Drugs don’t work in patients that don’t take them.”
— C. Everett Koop, MD

Reference:
Understanding the Terminology

“Taking medication like my doctor tells me to.”

Adherence
- similar concept as compliance, but typically with a more active and collaborative role for the patient.

Compliance
- describes the consistency and accuracy with which a patient who follows the prescriber instructions.

Persistence
- refers to the continued use of the prescribed medication regimen over time.

• Several terms used – Compliance, Adherence, Persistence- all are similar and often used interchangeably; however each reflects a different view about the role between patient and provider.

• A fourth term is gaining popularity in Europe- “Concordance” is similar to compliance/adherence but implies a more active partnership between patient and clinician. Not used with any frequency in the US.

• Important to remember that these are industry and research terms... typical patient doesn’t know what “medication adherence” is, they just know if they are (or aren’t) taking their medication the way their physician told them to. This can be important in member communications and patient intervention.

• Asking a patient if they “are taking (or adherent to) their blood pressure medications” or asking if they “are taking their medications exactly they way the physician told them to” can yield very different responses.
How Do We Measure Adherence?

Medication Possession Ratio (MPR) and Proportion of Days Covered (PDC) are the two most common formulas used to estimate patients’ adherence to chronic medications. Both formulas use prescription fill data to calculate the percentage of days for which the patient has medication on-hand to take for their chronic conditions.

Examples of adherence measures for diabetes and cardiovascular medications can be obtained from the Pharmacy Quality Alliance (PQA) at www.PQAalliance.org.

Medication Possession Ratio & Proportion of days covered are the most common measures of adherence. It is important to note that both methodologies measure prescription fill data; therefore, the results calculate how much medication the patient receives not if the patient actually took the medication as prescribed. Other methodologies such as patient self-reported data have been evaluated; however, the accuracy of self-reported data is low. As a result, MPR is currently the accepted metric for adherence. A MPR of 80% or greater is generally accepted as optimal therapy.

Example: PQA PDC Measures for diabetes medications and cardio-vascular disease (beta blockers, ACEI/ARB, lipid-modifiers)

Adherence is a multidimensional phenomenon determined by the interplay of five sets of factors, here termed “dimensions”, of which patient-related factors are just one determinant. The common belief that patients are solely responsible for taking their treatment is misleading and most often reflects a misunderstanding of how other factors affect people’s behavior and capacity to adhere to their treatment. The reasons a patient does not take their medication as prescribed are complex; for this reason, there is no “silver bullet” to solve the problem and solutions must tailored for a given population.
Adherence can be active (i.e. I chose not to take my medication) or passive (i.e. I forgot, didn’t understand directions, etc)

Examples: (note to presenter: in the appendix section there are additional slides with more information for each “dimension” that can be used here if appropriate for a specific audience)

• Social/Economic: We will discuss later how cost/benefit design can impact adherence rates. The potential for cost to play a factor in non-adherence increases when the socio-economic status of the population is low.
• Patient-related: patients perception of their disease and the value of treatment is critical. Often patients indicate that they are afraid of becoming dependent on medication- even if the medication is not an addictive substance.
• Therapy-related: The more complex the drug regimen the greater chance for non-adherence. In a recent study (Association between prescription burden and medication adherence in patients initiating antihypertensive and lipid-lowering therapy AM J Health Syst Pharm 2009 66: 1471-1477) found that among patients with 0, 1, & 2 prior medications 41%, 35% & 30% respectively were adherent to antihypertensive and lipid lowering therapy. Among patients with 10 or more prior medications, 20% were adherent.
• Condition-related: compliance tends to be lower for “asymptomatic disease” (i.e. hypertension, high cholesterol) vs “symptomatic disease” (back pain)
• Health Care System: The patient may not be clear on the physician’s instructions and/or the physician may never take the time to discuss adherence with the patient

Reference:
# The Adherence Estimator®

<table>
<thead>
<tr>
<th></th>
<th>Agree Completely</th>
<th>Agree Mostly</th>
<th>Agree Somewhat</th>
<th>Disagree Somewhat</th>
<th>Disagree Mostly</th>
<th>Disagree Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am convinced of the importance of my prescription medication</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>I worry that my prescription medication will do more harm than good to me</td>
<td>14</td>
<td>14</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I feel financially burdened by my out-of-pocket expenses for my prescription medication</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>


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The Adherence Estimator® was designed to be administered shortly after the initiation of new therapy and was designed to be completed for each new medication prescribed.

**ADD UP THE TOTAL NUMBER OF POINTS FROM THE CHECKED BOXES**

**Score Interpretation:**
- 0: Low risk for adherence problems
- 1-7: Medium risk for adherence problems
- 8+: High risk for adherence problems
Why Should I Care About Adherence?

“Lack of medication adherence is America’s other drug problem and leads to unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life, and even death.”

Reference:
The Impact of Poor Adherence: Consequences

- Unnecessary disease progression and complications¹
- Reduced functional abilities and quality of life¹
- Additional $2000 per patient per year in medical costs and physician visits¹
- 33% to 69% of medication-related hospital admissions²
- Increased use of expensive, specialized medical resources³
- Unneeded medication changes⁴

The impact can be tremendous not only to the patient but to the plan sponsor/employer.

Poor adherence can impact the health, welfare and productivity of your employees. Important to establish a plan to evaluate to what extent poor adherence is impacting your workforce and your bottom line.

The first two bullets relate to the clinical or patient-related outcomes such as disease progression or reduced QOL.

The remaining bullets identify the impact on the direct costs of treating non-adherent patients.

- Additional $2K PPPY in direct medical and physician costs
- 1/3 to 2/3 of all medication-related hospital admissions are associated with non-adherence. (Other reasons for medication related admissions may be adverse drug reactions, drug-drug interactions, medication over/under dose, etc.)
- When we see disease progression due to non-adherence we also see an increase in the use of expensive, specialized medical resources and tests as well as the addition of unneeded medications to treat a patient who may not be experiencing a failure/complication of the original medication prescribed by their physician- they are in reality the physician is unknowingly treating the effects of under/over medication due to poor medication compliance.

References:
Just showed you a sampling of the many statistics that exist around the impact of poor adherence. Let’s use the results of this well known retrospective study on adherence (Sokol, et al.) to help illustrate the correlation between adherence and outcomes.

As you can see- as medication adherence rates increase, the total medical spend (medical and rx) for those patients decreases. For example for those who were only adherent 1-19% of the time- the total medical costs were $15,186 per patient; for those who were adherent 80-100% of the time (80% or greater is generally the accepted “optimal” adherence value) the total medical spend was only $6,377 per patient.

You might ask- wouldn’t my costs increase because my members would be taking more medications as they adherence increases? To answer that, this same study looked at medical cost versus pharmacy cost for a given therapeutic class....... (next slide)

Reference:
Ideally automate this slide to allow a red circle around the 1st column showing costs for patients who were 1-19% adherent and then a second circle for those with adherence rates of 80-100. There is a lot going on in this slide so it may be helpful to focus the attention of the audience.

lacoe, 2/21/2010
This slide illustrates a similar relationship between total medical spend and increasing adherence rates. In addition, as you can see the pharmacy cost (the blue portion of the bar graph) increases as patients take more of their diabetes medications- at the same time the medical cost per patient decreases- resulting in a lower net per patient spend as adherence improves.

Reference:
I recommend automating so presenter can walk through the example in the notes—first a red circle around the portion of the bar graph showing $55 in rx spend per patient in the 1-19% example, then one around the $763, then another color circle around the entire first bar then a fourth circle around the entire last bar. Again—this can be difficult to walk through with an audience so may be helpful to focus them on the example.

lacoe, 2/21/2010
Improving Adherence Improves Outcomes

Demonstrating the Value of Medication Adherence*

- Clinical outcomes: 49 of 57 (86%) studies were positive
- Utilization outcomes: 25 of 31 (81%) studies were positive
- Economic outcomes: 12 of 21 (57%) studies were positive

Over the last several years there have been many studies looking at the impact of medication adherence. Particularly in the last 5 years, the amount of information in this area has increased significantly - could not possibly discuss all of the studies so this slide outlines an analysis of studies published from 1974 through July 2008 on the topic of medication adherence. The individual study results were reviewed and this chart reflects the overall percent of studies that showed a positive or neutral, or negative result.

- Studies evaluating clinical outcomes: 57 studies reviewed - 86% positive impact/ 12% neutral impact/ 2% negative impact
- Studies evaluating impact on appropriate utilization of healthcare services (i.e. less ER use and hospitalizations) : 31 studies reviewed - 81% positive impact/ 16% neutral impact/ 3% negative impact
- Studies evaluating economic/cost outcomes: 21 studies reviewed - 57% positive impact/ 29% neutral impact/ 14% negative impact

Note: If anyone asks for more information on methodology, specific studies reviewed, etc. a full copy of “FOCUS- Value Based health Management: A Closer Look” can be obtained through GlaxoSmithKline.
Study background: The Rand Corporation conducted a retrospective analysis of 30 large employers covering 528,969 beneficiaries continuously enrolled for up to 4 years. The study reviewed medical and pharmacy claims for these patients. Data were provided by Ingenix Inc. (UHC). The objective of the study was to determine how changes in cost-sharing affect medication use by privately insured patients. Chronic conditions were defined as involving 2 or more medical claims and at least one prescription in a designated treatment class.

- Among the conditions assessed, the study concluded that when co-pays doubled — for generic and “preferred / formulary brands” — people with asthma cut their use of asthma drugs by 22%. Diabetics cut their use of diabetes drugs (except insulin) by 23%.

So the initial goal sought by most payers looking for line-item budget reductions was achieved. The pharmacy budget decreased. Patients made less use of the system...in the short term. But what was the long-term impact? (next slide)

Reference:
Among patients with asthma, diabetes and gastric acid diseases: as the use of prescription drugs dropped, use of other, more costly, services increased.

According to Goldman’s analyses, when patients with diabetes and asthma aren’t taking their medicines, their use of other medical services increases.

Visits to hospital emergency rooms increased 17%. Hospital stays rose by 10%. And we know that emergency rooms and hospitalizations are among the most expensive ways to care for chronic diseases.

The data show that drugs can control disease and lower the costs of medical care over the long-term. But increased medical cost is not the only economic impact to an employer..... (next slide)

Reference:
In order to understand the full cost associated with poor employee health (poor medication adherence is one of many factors that contribute to poor health) one must understand the larger picture factoring the costs associated with productivity. This slide was shared with permission by the Integrated Benefits Institute (IBI) and is based on data from the 2006 Mercer Employer Annual Survey. While the majority of medication adherence solutions focus on impact to total medical spend... there is a significant potential for productivity-related savings, as well.
What Can Be Done to Improve Medication Adherence?

“A common assumption around cancer treatment is that a patient, given the choice of self-administered chemotherapy will be 100% compliant. Evidence suggests otherwise and points to patients administering these drugs inconsistently and irregularly. Compliance rates in some studies are as low as 20%.”

Reference:
Are You Asking the Right Questions….

…of your organization?

- How does medication adherence fit with your overall health management strategy? (eg, Does your health risk assessment incorporate medication adherence questions? Does your benefit rely on rewards or penalties to promote desired behaviors? etc)

- Do other programs/touchpoints exist where medication adherence can be addressed? (eg, a disease management program and/or on-site clinic)

- Do you have clearly defined objectives/measurements for your adherence program? (eg, improved MPR, decreased medical costs, etc)

Here are a few questions to get you started as you begin to evaluate the impact of adherence in your plan. These questions serve as an initial point to assess your organizations goals around improving medication adherence and outcomes.
Are You Asking the Right Questions....

...of your data?

- Do you know the medication adherence rates for your plan?
- What calculations and assumptions were used to create the adherence reports? Was any data excluded? What timeframe does the data represent?
- In addition to overall adherence rates, what is the breakout of the percentage of members with a medication adherence of less than 50%, 50% to 79% and 80% or greater? It is important to know how many patients are sub-optimal—not just what the average is

Here are a few questions to get you started as you begin to evaluate the impact of adherence in your plan. These questions serve as an initial point to assess your pharmacy data. Once adherence/ non-adherence patterns are identified, there is additional opportunity to further analyze the medical and/or productivity data.
Are You Asking the Right Questions….

…of your data?

- Ask for adherence rates separately for each benefit design as benefit design can impact adherence
- Are there any patterns in the adherence rates that may identify appropriate solutions? For example, patients with specific demographics, plan design, comorbidities, disease states, etc may have poor adherence. If a pattern is identified, it is easier to customize the appropriate solution

Here are a few questions to get you started as you begin to evaluate the impact of adherence in your plan. These questions serve as an initial point to assess your pharmacy data. Once adherence/ non-adherence patterns are identified, there is additional opportunity to further analyze the medical and/or productivity data.
Are You Asking the Right Questions....

...of your service provider?

- How do you ensure that the patient is receiving the best medication to treat their condition?
- What programs and resources do you have to address non-adherence?
- Do the programs differ for prescriptions obtained at retail/mail or specialty? By disease state?
- How do you identify “high potential” non-adherent patients?
- Do you identify or intervene with the undiagnosed patients or those that do not get the initial prescription filled?

Many vendors currently offer or are in the process of developing tools and services to promote medication adherence. It is important to understand what products and services your vendors offer and how these programs are administered. As we have discussed, non-adherence is multi-dimensional; therefore it is very likely that there are several areas of your benefit that could/should incorporate an adherence strategy-- for example the Rx benefit, a DSM program, your HRA (health risk assessment), etc. But it is important that there is consistency in message across all benefit programs in order to ensure the best results.
Are You Asking the Right Questions…. 

…of your service provider?

- Is adherence evaluated using the nationally endorsed measures (eg, PQA-NCQA) measures?
- What educational or communication components are available to support adherence?
- What evidence will you provide to demonstrate and evaluate that the programs are increasing adherence?
- How will you coordinate with and/or support the efforts of my disease state management, wellness or medication therapy management programs to ensure adherence messages are incorporated and messaging is consistent?

Many vendors currently offer or are in the process of developing tools and services to promote medication adherence. It is important to understand what products and services your vendors offer and how these programs are administered. As we have discussed, non-adherence is multi-dimensional; therefore it is very likely that there are several areas of your benefit that could/should incorporate an adherence strategy-- for example the Rx benefit, a DSM program, your HRA, etc. But it is important that there is consistency in message across all benefit programs in order to ensure the best results.
How Are Employers Analyzing Medication Compliance?

What are other employers doing to assess medication compliance opportunities within their programs? This slide shows the results of a survey of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council- the survey was conducted in June/July 2009. The most frequent activities currently utilized by employers are evaluating their prescription data and evaluating self-report data such as HRA or survey data. While fewer employers have utilized integrated prescription drug, medical and productivity data- many employers indicate they will be doing so in the next 18 months.

Reference:
Survey of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council. Conducted in June/July 2009.
What Solutions Have Been Tried?

- Refill reminder programs
- Auto-refill programs
- E-prescribing
- Reducing member cost share for chronic meds
- Pharmacist-provided medication therapy management (MTM) programs
- Incentives tied to participation in a MTM program
- Education and communication materials for patients

None of these programs provides a “one stop solution” However these initiatives can be very useful tools in improving adherence

- Refill reminder programs are available through several PBM and health plan vendors. Patients are contacted via test message, email or phone to remind them it is time to order a refill.
- In auto-refill programs the dispensing pharmacy automatically refills a chronic medication when the days supply has lapsed. Often an outbound call from the retail pharmacy reminds the patient to pick the medication up. Mail service medications are merely refilled and the medication is sent to the patient. Typically this is a service patients may opt-into.
- There are several companies leveraging technology to support patients self-manage their care. For example, there is a free website (www.mymedschedule.com) that offers medication reminders and/or refill reminders via text or email. In the absence of similar programs offered through a PBM or other vendor, an employer could provide a link to this site for employees and their dependents.
- As e-prescribing becomes more common, it will facilitate the process of getting the original prescription to the pharmacy and provide more robust prescription data for monitoring adherence
- In cases where member cost is a factor, employers have implemented benefits where copay has been reduced or eliminated in select therapeutic classes in order to reduce the financial barrier to adherence
- Several employers have linked the reduction in copay to an action or activity required by the patient such as participation in a Disease management program, participation in a MTM program and/or maintaining a specified adherence threshold for chronic medications
- Providing patients access to appropriate education about their disease state, medications and benefit design are critical components of addressing adherence. In fact, in a few slides I will show you survey data that suggests just how important it is.
• Many programs are available through your PBM and/or health plan. One example announced recently (Feb 2010) is a new program being launched by United Healthcare called “Refill and Save”. The program will apply to certain asthma and depression medications. Patients that refill their medications in a timely manner will receive a copay reduction of $20 @ retail or $50 @ mail. The initial prescription fill is not eligible for discount as this program focuses on promoting timely refills. This is a new program so cost savings and outcomes are not yet available.

• Another organization driving adherence is PQA. PQA, Inc. is a membership-based alliance that represents a broad group of stakeholders including pharmacist practitioner groups, health plans, pharmacy benefit management companies, government agencies (including CMS), employers, long term care pharmacy groups, pharmaceutical manufacturers, consumer groups, patient advocacy organizations, and quality improvement organizations. The mission of PQA is “to improve healthcare quality and patient safety through a collaborative process in which the key stakeholders agree on a strategy for measuring performance at the pharmacy and pharmacist-levels; collecting data in the least burdensome way; and reporting meaningful information to consumers, pharmacists, employers, payers, and other healthcare decision-makers to help make informed choices, improve outcomes and stimulate the development of new payment model. In 2009 they endorsed 15 medication therapy quality metric for chronic diseases which are being adopted nationally by providers and providers of healthcare services.

• Adherence based contracting- an example is the agreement between Health Alliance Medical Plans (covering lives in IL and Iowa) and Procter and Gamble. P&G agreed to cover costs of non-spinal osteoporosis fractures in women who take Actonel. The costs were reimbursed to HAMP through discounts and rebates. During the initial phase of the project the reimbursement to HAMP was 79% lower than the maximum anticipated. For more information, a case study can be located at the CHVI website (www.vbhealth.org)

• Smart pill boxes/ reminder technologies- many companies working on leveraging technology to improve adherence. GlowCapsConnect™ is a system for monitoring and/or providing feedback to patients that miss a prescribed dose. The GlowCap medication bottle can passively collect data adherence data and transmit it via a wireless network. In addition, if a patient does not take the prescribed medication the bottle cap can be programmed to glow providing a visual cue to take the medication, beep providing an auditory cue and/or the data collected and sent via wireless network will trigger a phone call reminder.

• In January 2010 Novartis secured exclusive license and options on drug-delivery technologies. What is a “smart pill”? When a patient takes a medication the stomach fluids activate the edible communications device within the pill. This sends wireless signals to another chip worn as a patch or embedded just below the skin of the patient. The information can be uploaded via a smart phone and used by the physician to ensure medications are being taken at the right time, spot adverse reactions, dosing adjustments that should be made, etc.

• We have just talked about a number of programs and tools for improving medication adherence- lets walk through a few real life examples of how these programs have been implemented by employers and what lessons they have learned…. (next slide)
Value Based Health Management is a philosophy of structuring a benefit in order to reduce overall health costs and improve the health status of the patient. Improving medication adherence is a often a core component of VBHM. VBHM has been around for several years and adoption rates by employers has increased- lets take a look at a recent survey conducted by Buck Consulting on behalf of the Center for Health Value Innovation. This table outlines the employer response when asked what would you do differently if your VBD program could be deployed again? Overwhelmingly the response was to enhance employee and health care provider communications followed by holding vendors accountable for outcomes.

Reference:
Innovative Medication Adherence Initiatives and Results

**Employer A**
- **Adherence Initiative**
  - Real-time outreach trigger on new Rx's
  - Proactively talk with employee at beginning of their disease
  - Onsite pharmacist conducts medication counseling
- **Pharmaceutical counseling**
- **PBM initiative**: if patient has targeted chronic disease or hasn't filled prescription, they would be offered option to talk with a PharmD about condition; PharmD will have pharmacy record and patient data

**Result**
Not in yet

**Employer B**
- **Adherence Initiative**
  - Change co-pay for insulin to $10
  - Offer credits toward co-pays for participation in diabetic disease management programs
  - Physician pay-for-performance program for diabetes

**Result**
HbA1C measurements improving
Waiting on more results

*Continued...*

This slide shows case studies provided via a series of interviews of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council- the survey was conducted in June/July 2009. The survey and interviews were designed to assess Employer Medication Compliance Initiatives.

• Employer A created a strategy to enhance patient outreach and education. By providing patients with access to pharmacist counseling and better information they hope to see an improvement in adherence and the overall health status of their patients. This initiative was too new to measure the outcomes.

• Employer B combined the strategy of reducing financial barriers and providing financial incentives to patients and prescribers in order to improve diabetes management. Early results show improvement in HbA1C measures which are an important indicator of optimal diabetes management.
Innovative Medication Adherence Initiatives and Results

Employer C

**Adherence Initiative**
- Healthy behavior credit—$20 per week
- Have to take the HRA, be smoke free and do what you’re supposed to do (fill a prescription, attend a program, follow-up visit to physician, other identified care opportunity)
- Lower co-pays on drugs for high cholesterol, high blood pressure, diabetes, and others

**Result**
- Increased compliance for 5 drug categories from 65% to high 80s, low 90% in one year

Source: Survey of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council. Conducted in June/July 2009.

Continued...

Employer C combined reducing financial barriers and offering a $20 per week credit as an incentive for being adherent to medications and other healthy behaviors. This employer reports increased adherence of 5 drug categories increasing from a sub-optimal 65% to high 80 and low 90 percent rates.
Innovative Medication Adherence Initiatives and Results

**Employer D**

**Adherence Initiative**
- Beginning in 2002, made high-value, chronic disease drugs free
- Built onsite free pharmacies
- Cash payments:
  - $50 if achieve >80% adherence to chronic disease medication with waived co-pays for diabetes, hypertension, and cholesterol drugs
  - $50 for completing smoking cessation program
  - $50 per time for seeing the same doctor twice a year
- Meet with vendors regularly, review data and hold them accountable for results including medication compliance rates
- Self-reported compliance question in HRA

**Result**
- The adherence rates for antihypertensives and statins increased 8 percentage points within one year
- Cholesterol levels and blood pressure averages dropped
- Low participation rates in wellness incentive program due to fear of employer knowing too much about employees’ health
- Self report compliance comparable to actual for small sample.

Source: Survey of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council. Conducted in June/July 2009.

(This slide shows case studies provided via a series of interviews of employers conducted by the Benfield Group on behalf of the National Pharmaceutical Council- the survey was conducted in June/July 2009. The survey and interviews were designed to assess Employer Medication Compliance Initiatives.)

And finally- Employer D is an example of a more mature, comprehensive program. The strategies likely evolved over the eight years of the program as the employer indicates they watch their data and outcomes closely. In addition they have combined reducing financial barriers, increasing access to care via free on-site pharmacies, wellness strategy and HRA strategy integration to promote a culture of health. They saw a marked increase in adherence rates as well as an improvement in clinical outcomes such as cholesterol levels and BP.)
Finally- many of you have heard of the Ashville Project. Because of the early success in Ashville, several programs have been created to determine if it is scalable and replicable in other geographies. One such project was done in Lancaster PA.

The BRiDGE Project

• Like Ashville the program is based on a combination of financial incentives for patients who participate in the program and actively manage their diabetes. Patients agree to a monthly visit with a diabetes trained and certified local pharmacist for face-to-face coaching.

• For employers, first-year results indicated a $5,800 reduction in healthcare spending per participant.

• While regular healthcare exams increased 34%, total healthcare costs decreased 30%.

• Employees in the program were more compliant in treatment and more likely to fulfill doctor requests for periodic health exams.

• Employers create a union between physicians, pharmacists, and patients. Physicians and pharmacists act as a coach to help patients learn about healthy lifestyles and treatment options.
Questions?

www.fmcpnet.org
Thank You