Clinician Perspectives of Primary and Secondary Medication Non-Adherence

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Background

- **Primary non-adherence**, defined as not filling an initial prescription, and **secondary non-adherence**, defined as filling only the first prescription and none subsequently, are challenges for healthcare systems and may lead to increased healthcare utilization and worse patient outcomes.[1,2]
- Medication adherence is low overall, with 30% of patients not filling their first prescription and worse rates among certain classes of drugs, as well as for specific subpopulations.[3,4]

Study Objective:

Systematically gather provider insights on treatment and prescribing practices, patient communication, disparities, resources, and follow up that may contribute to oral anticoagulants (OAC) and oral anti prostate cancer medication (OAPM) non-adherence.

Methods

A mixed methods approach included:

- A database study using overlapping clinical electronic health record (EHR) and administrative adjudicated claims to describe primary medication adherence and to potential disparities among select sub-populations.
- Audio recorded qualitative interviews following a semi-structured interview guide were completed with MDs, APPs, and PharmDs in both primary and specialty practices.
- Rapid qualitative analysis informed by the framework method utilizing a matrix format was used to identify themes and subthemes.
- The interview guide focused on the following domains:
  - Organization Current Practices, Data Sources and Initiatives
  - Provider Prescribing and Follow Up Communication
  - Perceived Patient Barriers for Adherence and Strategies to Address Non-Adherence
  - Gathering Insights and Reactions to Quantitative Database Findings

Results

- Database study results (presented separately at this conference) found that **for both OAC and OPCM, patients who do not fill within 24 hours are much less likely to become adherent.**
- Six interviews (averaging 50 minutes) were completed with providers to discuss contributors to adherence.
- Providers interviewed had an average of 19.3 years in practice (range 12-30) with 12.7 years at their current health system (range 3-28)
- **Providers believe 90% of patients complete an initial fill, however at the time of script, patients have a 76% chance of becoming adherent to an OAC and 69% chance to become adherent to OPCM.**

Results (continued)

"[It's a challenge for] Afib [where] the patient might not feel that diagnosis versus DVT when they feel that disease" -(PharmD)

"[Our] team of nurses and pharmacists get data from Medicare Part D payers and look at adherence rates. We call those patients and encourage refills; we discuss why they may not be adherent." - (PharmD)

"Cost is the main barrier with DOACs. Any blood thinner is risky, but these are safer than older ones we have"- (MD)

"Nurse reviews medication list, then physician [makes] sure [the] patient is adherent. Importance of adherence reinforced. Nurse reviews and updates the med list. The initial workup has been done." - (MD)

Main themes	Subthemes	OAC Examples	OPCM Examples
Patient Factors	Disease state / medication education	- VTE may come with urgency that increase adherence in comparison to Afib	- Disease state education needed
	Cost	- Copay assistance cards, sample and starter packs are available supports, but cost barrier is not always communicated with provider - ***"patients don't want to be a squeaky wheel"***	- Limited financial assistance programs given specialty nature of drugs. - Generic drug can have challenging side effects and not viewed as standard of care.
	Medication factors	- E-prescribing ***"out of sight out of mind"*** for patient, especially older - Polypharmacy was surprisingly not viewed as a barrier possibly due to the role of caregivers or adding one more medication not viewed as a big of a deal by patient.	- Medication requirements/side effects impact adherence (e.g. take with food and prednisone, fatigue) - Medication side effects impact patient's quality of life (sexual function). Clinicians reported many patients do not share diagnosis or treatment with partner. - Delays in initial fill generally related to administrative burden rather than patient behavior.
Provider/Clinic Factors	Provider-patient communication	- Shared decision-making discussions - PCP may not have sufficient time/bandwidth to focus on OAC	- Shared decision-making for oral therapeutic vs injectable - Urology focus on procedural interventions while medical oncologists focus on medication
	Clinic support	- Office staff support for prior authorizations, financial assistance programs, starter packs, samples - Importance of after visit summary	- Prior authorization assistance and workflow processes for medication initiation
	Pharmacy engagement	- Pharmacy reports, reminders and supports (including on samples or starter packs on site on day of initiation)	- Prior authorization support, specialty pharmacy communication - Medication reminders and support
Health System Factors	Adherence data reports/review	- Clinics and providers need access to and training on adherence reporting tools for timely fills.	- Inconsistent fill data shared with providers by specialty pharmacies, but more robust access and reports needed.
	Multidisciplinary teams	- Improved transitions needed for care from ED and inpatient to outpatient care.	- Follow up within 4 weeks of medication initiation - APP and MD engagement with patient
	Medication procurement support	- C-suite engagement for administrative and financial support to stock samples and have adequate support staffing for medication adherence.	- System workflow processes for medication initiation in partnership with specialty pharmacies

"We have specific specialty pharmacies we work with that we've built relationships with to streamline the process for the patient"- (MD)

"I try to address adherence barriers and give patient choices as to what do you think would be most successful? What is your day like? What other medicines do you take? Do you travel a lot?"-(APP)

"Sometimes patients may not be upfront about why they don't want to take it… You really have to spend some time and walk through things "- (MD)

"Everyone put a clinical pharmacist on their team. But how do you integrate them? What do they do? What do you do?"- (APP)

Opportunities

Initial Prescribing

- Shared decision making to ensure therapy aligned with patient's medication cost and lifestyle for regimen and follow ups
- First few days key to adherence

Initial Fill

- Payment assistance programs
- Nurse/social worker/MA/pharmacy engagement for prior auth approval and disease state education
- Starter pack, samples, copay cards, on site initial fills immediately after prescribing

Persistence

- Surescripts data or other way for feedback loops to prescribers on objective medication fill data
- Standardized patient outreach/education and documentation within EHR (e.g., note, smart phrase)
- Multidisciplinary engagement and communication feedback loop

"If you don't have a coordinated workflow of communication and documentation, you're depending on good people and good workers to take the extra step, to dig a little deeper to what's going on. But if you can examine how the process works, get these teams together to not be reactive but proactive. That should be the normal workflow."-(MD)

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Scan QR code below for references:

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