

**MEDICATION ADHERENCE:
A CASE FOR INDEPENDENT PRACTICE ASSOCIATION
INVOLVEMENT**

White Paper

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Abstract: Medication Adherence And How ICLOPS Helps IPA and PHO Physicians Achieve Better Clinical Outcomes

Problems stemming from inappropriate, inconsistent, or contraindicated prescriptions are a major source of patient medical complications and death. This recognition has led to a variety of quality efforts and regulations aimed at improving medication reconciliation during hospital inpatient stays. While this is essential, most medication issues begin in the outpatient environment, and little has been done to track patient use of prescriptions.

Independent Practice Associations (IPAs) and Physician Hospital Organizations (PHOs) have a perfect opportunity to stem medication adherence problems at the onset of treatment, when it is most effective. They are better able to help physicians to identify patient issues and track adherence. Individual physician practices have few incentives to adopt these programs on their own, because of the time and work involved. For IPAs and PHOs, however, medication adherence can be an essential ingredient of clinical integration plans, or pay-for-performance contracts.

ICLOPS helps IPA and PHO achieve quality goals by providing a complete solution to quality measurement and management that is very difficult and expensive for the organizations to build on their own. ICLOPS has developed a unique approach to supporting physicians in independent practices, yet meeting the demands of payers and other outside entities to demonstrate quality.

This paper presents options for IPAs to consider in helping member physician practices meet and demonstrate higher standards of quality. These activities require no system changes or new work for member physicians. ICLOPS enables IPAs to face the challenge of measuring clinical performance in multiple independent practices with different practice environments, clinical styles, and information systems.

A medication adherence program can be pursued by IPAs and PHOs as part of a larger clinical integration plan, or independently undertaken. Medication reconciliation or adherence program affects all physicians in an organization and therefore may be a very good lead-in to other, more specific IPA clinical quality efforts.

ICLOPS is a company that analyzes physician practice data to manage quality with targeted communications to patients and prompts for physician visits. The communications increase revenue,

quality, and patient retention for physician practices by ensuring better follow-up care, especially for chronic disease patients; improve patient management of their health; and increase patient satisfaction with physician services.

Problems Caused by Poor Medication Adherence

Poor medication adherence has an enormous impact in both patient health outcomes and higher costs. Medication non-adherence is estimated to cost the US healthcare system more than \$100 billion of preventable costs per year. Ten percent of US hospital admissions are the direct result of poor compliance with prescribed medication, with annual costs estimated at \$48 billion.¹

There are documented problems associated with lack of medication adherence by patients with particular conditions. At least one third of hospital admissions for heart failure are the result of noncompliance (both with medication and dietary regimens).² Adherence to inhaled corticosteroids is poor among adult patients with asthma and is associated with poor asthma outcomes. Poor adherence to inhaled corticosteroids accounts for the majority of asthma-related hospitalizations.³

The reasons for patient non-adherence are complicated. Patients stop taking their medications because they consider them ineffective or because of side effects. In many cases this occurs they don't believe they can afford prescriptions, or they weigh the perceived value of the medication against the cost. With asymptomatic conditions, patients may not even fill their prescriptions because they don't believe they need the medications.⁴ One study showed a 75% discrepancy between patients' medical records of medications and dosages, and what patients reported they were actually taking, especially in high risk groups - the elderly and those taking multiple medications. The discrepancies covered all classes of medication, and included differences in dosage, not taking the recorded medication, and taking non-recorded medications.⁵

Poor medication adherence is common throughout the age and educational spectrum, although the effects are worse for the elderly. Even among health care professionals who should be more aware of the risks, a study of medication adherence revealed that about 80% of patients (who are also health care professionals) reported taking prescription medications 80% of the time.⁶

¹ (National Pharmaceutical Council 1993, Archives of Internal Medicine 1995, National Council for Patient Information and Education 2004)

² American Journal of Medicine 2/17/97.

³ Journal of Allergy & Clinical Immunology. Dec. 2004.

⁴ American Journal of Medicine 2/17/97.

⁵ Archives of Internal Medicine 7/24/00

⁶ Southern Medical Journal, June 2000.

In spite of problems generated by lack of medication adherence, it appears that physicians rarely discuss this topic with patients. Few patients with chronic illnesses who are at risk of or are experiencing problems related to prescription medication costs report that their doctors had asked them about possible medication payment difficulties.⁷ This creates a potential liability for physicians; they cannot manage the care of a person with chronic disease while ignoring compliance with prescribed medication.

There is evidence that medication adherence can be improved and that early and better communication between physicians and patients is a key ingredient. Barriers to medication adherence occur early in therapy and result from patient perspectives on the illness and treatments. Establishing successful adherence early when treatment is started is important to maintaining long-term adherence.⁸ There is also more evidence that a multi-faceted approach to communication, to engage the patient in decision-making and communication, will improve adherence.⁹ One study showed that efforts to simply provide patients with medication timetables and computer generated consumer product information does not improve drug adherence in primary care.¹⁰

⁷ American Journal of Medicine, 6/1/04.

⁸ Canadian Medical Association Journal 1/12/99

⁹ Drug & Aging 21(12): 793-811,2004.

¹⁰ Australian Family Physician. August 2003

Why Physician Networks Should Focus on Medication Adherence

Medication adherence, while difficult for individual practices, is an ideal focus for IPAs, PHOs, and large physician groups. As a practical matter, IPAs and PHOs are better capable of managing quality processes, including the development of clinical protocols, measurements, and peer review processes, than individual practices. But the benefit to the central organization is also high. Networks can demonstrate improved clinical performance required for pay-for-performance and clinical integration, both of which will bring significant additional revenues to the organization and to physicians. Some large organizations have found as much as a 15-25% difference in revenues because of the ability to negotiate in this environment.

IPAs and PHOs can also reduce malpractice risk through medication adherence programs. Whether or not the IPA offers malpractice insurance to its members or a subset of practices willing to share risk, there is no other quality effort that has as much potential to affect outcomes among a broad range of patients with chronic disease, nor that affects as many physicians in the organization.

Medication adherence is difficult to measure and address in individual physician practices. In fact, there are few known examples of adherence results in the outpatient setting, but the evidence points to lack of attention to this aspect of treatment. This is consistent with results from ICLOPS data and physician-reported results. In general, physicians view their clinical responsibilities to be delivered within the timeframes of patient encounters, and they expect patients to follow through on instructions and treatment plans. It is rare that physicians follow up on patients who do not meet expectations of visit frequency, or who do not complete prescribed labs and specialty referrals. In many cases these may go unnoticed while physicians deal with acute problems.

Poor medication adherence - and the underlying barriers to patient compliance - affects the quality of care associated with the treating physician and creates economic consequences. Patients not taking prescribed medicines are usually non-compliant in other areas and affect not only their own health outcomes but physician quality 'scores' as measured by NCQA and payer audits.

IPAs and PHOs can implement medication adherence programs in conjunction with other quality efforts or independently. For example medication reconciliation is a new JCAHO requirement for hospitals, and has physician prescription origins. Coordination of these efforts will increase the value of the organization to hospital partners and patients.

Medication adherence is also a big issue for pharmaceutical companies, who lose as much as \$60 billion annually on unfilled prescriptions. Initiatives to ensure that patients take prescribed medicines may be attractive candidates for grant funding. Additionally, successful programs could better position the IPA or PHO to participate in clinical trials, raising the marketability of IPA or PHO physicians.

ICLOPS: A New Approach for Medication Adherence

ICLOPS helps IPAs and PHOs to manage clinical quality in member physician practices using a 3-part system. This includes the analysis of data from physician practices, communications to patients, and point-of-care prompts for physicians. ICLOPS requires little effort from practices and no extra system costs, removing barriers to participation in IPA or PHO projects.

With ICLOPS, IPAs and PHOs can accomplish multiple goals - clinical integration of practices to permit negotiation of fee-for-service contracts without a messenger model; capability of succeeding in pay-for-performance contracts; and provision of added value services to member physician practices. Medication adherence projects can be a part of an integrated quality plan and help achieve each of these goals.

Key aspects of ICLOPS' services for IPAs and PHOs include:

- Extraction of practice data from physician practice management system for the identification of patients by condition, age, gender, and history. There is no need for interfaces or for physicians to change systems to participate.
- Creation of a centralized database to analyze and comparison of results across all practices. When all IPA practices participate, ICLOPS can perform analyses that track patients from one provider to another.
- Patient communications, including letters that incorporate physician letterhead and electronic signatures and are specific to patient names, gender, diagnoses, and status. Patient communications also include materials that convey standards of care and collect further information for ICLOPS analyses.
- Prompts to be placed in patient charts (for subsequent visits) along with copies of patient correspondence. These prompts are check-offs for physicians during the visit, and quality audit codes are attached to these prompts (such as additional AMA category 2 CPT codes). This allows for the capture of more relevant information.

ICLOPS implements two projects that improve medication adherence, one as part of a focused chronic disease quality effort, and the second as a broad-based independent initiative. Both are multi-faceted approaches that involve a deep level of patient engagement, physician communications, and monitoring of results over time.

ICLOPS Chronic Disease Follow-up with Medication Adherence. With IPA leadership, ICLOPS determines patients with chronic diseases to be tracked in IPA quality efforts. For primary care these normally include patients with a history of diabetes, hypertension, lipid disorders, CHF, CAD, and asthma. There are additional patients in cardiology or other specialty practices, should the IPA or PHO wish.

ICLOPS extracts copies of data from physician practices to create the IPA/PHO database and identify patients that will be tracked. These patients receive letters and personal services/medication records for them to monitor services they need and receive and record medications, for review during visits.

Prompts are placed in charts with copies of letters. The prompts are tailored to patient disease and to IPA or PHO quality efforts. They require little work by the physician – only checking boxes is required – and cue physicians to review correspondence sent to a patient and the patient’s personal record, and to record certain visit processes, such as anti-platelet therapy determination or depression screens. After the visit, the prompt may be attached to the encounter sheet for visit coding. This allows the incorporation of AMA category 2 and other customized codes into the future database, for quality evaluations. (Note: for practices with an EMR, ICLOPS assists the practice in developing an electronic prompt). The prompts change over time to address new quality efforts.

Patients also receive a second correspondence asking for feedback on the ease or difficulty of following the physician’s treatment plan, including medications. This collects data that ICLOPS analyzes and provides back to the IPA or PHO and the physician.

Medication Adherence - EMR Pilot. The purpose of this ICLOPS project is to use the advanced record-keeping capabilities of an EMR to improve patient compliance. Like all ICLOPS projects, a Medication Adherence begins with collection of information from the physician practice management system. In this case, data is extracted from the clinical system to show current patient prescriptions, for patients with chronic disease on ongoing medication. The EMR permits ICLOPS to identify the medication history of a patient.

ICLOPS uses the practice data to identify patients for the next phase of the project. Patients with chronic disease (or a limited selection) receive personalized mailings from the practice requesting them to submit medication information, preferably by directing them to a secure web site. ICLOPS then compares the recorded prescriptions with patient information.

ICLOPS forwards copies of patient letters to the practice with prompts for the physician to review results during the next office visit. Once the analysis is complete, ICLOPS also feeds information back to the physician to show patient-specific variations in medications, and prompts physicians for further data collection points.

ICLOPS' Multi-faceted Approach. ICLOPS can customize projects on Medication Adherence for IPAs and PHOs so that they can be pursued simultaneously. This is a real advantage where physicians' practice technology differs, and the IPA wishes to showcase the additional benefits of an electronic medical record.

ICLOPS' approach is multi-faceted and uses a combination of methods to improve patient adherence – direct patient communications, physician prompts to discuss medication regimens with patients, and interactive tools that encourage patient engagement and discussion about medication. Patients and physicians receive repeat communications or prompts, and these are refreshed to maintain high interest.

Patient involvement is a critical feature of all ICLOPS clinical projects, and is especially important for Medication Adherence. Research and other project results have shown that patients who are engaged are much more adherent than patients who are simply given directives by their physicians. Interventions that are multifaceted and include patients' perspectives are the most successful in achieving good therapeutic results.¹¹

¹¹ Drug & Aging 21(12): 793-811,2004.

Summary: A Case for IPAs and PHOs to Address Medication Adherence

IPAs and PHOs are well positioned to help physicians address emerging patient and quality issues. Originally organized around a financial risk model, these organizations now offer a structure for supporting physicians in the current physician practice environment. This is especially the case for organizations consisting of small and moderate sized physician practices, which typically do not have the infrastructure to support analysis of data or to undertake complex quality projects.

Unfortunately, availability of resources often limit the ability of IPAs and PHOs to undertake complex quality projects. The networks were often organized to contract for with health plans for capitated HMO patients, and the transition to focus on the overall support of physicians to meet the needs of patients has been difficult. However, there are compelling reasons for IPA and PHO leadership to embrace the change:

- A shift to PPO and POS fee-for-service business over the past several years ensures that most patients will have this kind of insurance coverage. IPAs and PHOs who fail to shift emphasis away from the management of capitated business will become obsolete.
- Reimbursement schemes are continuing to involve quality measurement, and these mechanisms will begin to “cut out” physicians who cannot measure or address quality performance. Because small independent practices have little capability to accomplish this, IPAs and PHOs can both achieve better reimbursement results and higher quality for practices by undertaking a few high-impact quality projects.
- Medication adherence and medication reconciliation are becoming high profile projects because they have heavy impacts in patient outcomes and costs. There is evidence that pharmaceutical companies, who have a stake in ensuring that patients take their prescribed medications, will partner with IPAs and PHOs to finance medication adherence projects. ICLOPS can assist by providing the system and processes to undertake these projects.