

***Vital Signs* Town Hall Teleconference**
Medication Adherence: Helping People Take Their Medicine
Q & A
September 20, 2016
2:00 pm ET

Steven Reynolds: Remember you can get in the queue to ask a question or make a comment by pressing star one. Say your name when prompted and the operator will announce when it's your turn. Please address your question to a specific presenter or indicate that it's a question for all of the presenters.

I encourage you all to share your own strategies, lessons learned, challenges, and success stories about this topic. We have quite a few states and organizations on the call, and this town hall is a forum for you to discuss and collaborate on different methods, practices, and experiences with helping people with hypertension stick to a medication regime.

Operator, we're ready for questions. Is there anyone in the queue?

Coordinator: Thank you. Currently I'm showing no questions at this time, but as a reminder -- star, one to ask a question at this time.

Steven Reynolds: So let me kick it off. Dr. Ritchey, what are some of the more common reasons patients cite for not taking their medicine as directed?

Dr. Matthew Ritchey: Thanks for that question. I think our other two presenters really more eloquently stated how in addressing some of these issues what are some of the common barriers to a patient not taking their medications on time. So I think some of the things that we

highlighted in our project are - one is this idea of primary nonadherence, even, that really isn't reflected in our results.

So we found that over a quarter of individuals who are actively - have started taking their blood pressure medicine don't continue to take their medication over a year's timeframe. But other research has also shown that there is this primary nonadherence or people who are given a script at the very get-go. Okay, you have high blood pressure and are given a script, but actually never go and fill that initial script.

So I think there's issues with that primary nonadherence that we need to address as well that unfortunately is not able to be collected or captured in the data that we have access to. So there's ensuring that patients get that initial script and actually go to the pharmacy for the initial fill. I think Dr. Garber really talked about that, especially making that linkage between the importance of taking your medication as directed and the condition you're trying to treat, and see how they're totally related to one another as far as improving blood pressure by taking your medication.

Also this idea of hypertension being a silent killer and it goes into that same umbrella that I just mentioned. Not having typically any signs or symptoms of having high blood pressure, but having the condition nonetheless that then could lead to these conditions that we're ultimately trying to prevent -- heart attack, strokes, the development of kidney disease.

Within the population that we specifically looked at the sixty-five and older that often have multiple comorbidities, sometimes the complexity of the medication regimen can come into play. And Dr. Garber talked about how some of the pharmacists that they're working for that are embedded within their group are going in and doing a medication reconciliation.

What are all the medications you're on? Do you need to be on all these medications? Are they all at the right dosage? Are there ways that we could maybe combine these

fixed dose combination pill format? So it reduces the number of pills you have to take every day? Is there a way if you're having to take a pill twice a day - is there a way that we can get that at a dosage that you only need to take it once a day? Those kind of ideas.

Addressing side effects, whether they're side effects the patients have already had and maybe requires a change in intensity or a change in medication or these preconceived notions about specific medications or having these potential adverse effects. So potentially looking at that.

And then a big idea is just this idea of - you forget. We get busy in our daily regimens and just doing things, so we forget to take our medication. And when we're doing chronic disease medication that you're taking day in and day out, sometimes it gets pushed to the side just because we have so much other stuff going on.

So figuring out what are other activities during the day that individuals are participating in, whether it's just brushing their teeth or things like that that they do on a daily basis, and trying to link them up with taking their medications, again, to help remind them.

And in the same vein, ideas about using pill boxes or even now in our modern day using apps that help remind you - hey, did you take your medications? Which specific medications? What are they being used for? That whole thing where we have it at our fingertips to be able to track.

And then finally, the idea of cost. Again, some of those ideas were already expressed by the other two presenters as well - is when there's a generic option, go to the generic option which typically is going to be cheaper. And try to figure out where does the cost burden lie for this patient and what are things that we can potentially do to help the patient overcome that barrier to them taking their medication as directed.

Steven Reynolds: Thank you Dr. Ritchey. Operator, do we have callers in the queue?

Coordinator: Thank you. Our first question is from Karin Bolte of National Consumers League. Your line is open.

Karin Bolte: Great, thank you. I actually had a - I wanted to share a little about [NCL's Script Your Future campaign](#), which has a lot of really great resources that I thought some of the people on the call might be interested in accessing for their populations. And, in fact, we've been a partner with CDC's Million Hearts program.

And we have what we've found to be very helpful to patients - is we have wallet cards that fit in their wallets where they can list all their different medications that they're taking, the reasons that they're taking it, the dosage. And we have those available. You can go to our Web site, which is [ScriptYourFuture.org](#), and order those materials from us.

They're also available for downloading and even cobranding with your organization directly off of our Web site. And they're currently available in six languages. We have them available in English, Spanish, Chinese, Vietnamese, Hmong, and Russian.

And to the point of this call, we've really focused on patients with chronic diseases, including cardiovascular disease and high blood pressure, taking high blood pressure medications. Also diabetes and those with respiratory conditions like asthma and COPD. But the resources are really useful across the board.

So, I would definitely encourage everyone to go to our Web site and see the materials that we have available that might be helpful for your patients in your areas. And we can always be reached through info@scriptyourfuture.org or you can contact me directly at NCL. And my email is Karin -- K-A-R-I-N, B (for boy), [@nclnet.org](#). (KarinB@nclnet.org) Thanks.

Steven Reynolds: Thank you, Karin. Operator, someone else in the queue?

Coordinator: Next question from Dr. Jitendra Kapoor, A&M University. Your line is open.

Dr. Jitendra Kapoor: Yes. Would I be able to get a hard copy of the presentation?

Woman: Yes. That will be available next week on the Web site.

Dr. Jitendra Kapoor: Thank you.

Coordinator: Next question from Deirdre Paine of Walmart. Your line is open.

Deirdre Paine: Good afternoon. Of course we're a community pharmacy and we are on the front lines of a lot of the primary medication nonadherence that is so hard to capture. Of course we're using the medication safety management NPM services. I wanted to reach out to find out - have any of you all partnered with community pharmacists locally when it comes to your patients that are truly having difficulty managing their blood pressure? And if so, what are some of your experiences and what would be most useful for us in communicating with you all?

Dr. Larry Garber: So this is Larry. I'll pick up on that. So we actually have done a pilot with one of the pharmacy chains looking at medication adherence for - not for the primary nonadherence, but for chronic medication where we actually get faxes when they think that the patient is being noncompliant with their medications. We've actually seen the same thing from health plans.

And the - to be honest, we've found a lot of false positives. In other words, a lot of the faxes have not accurately identified people who aren't being compliant. It often is due to cases where we've discussed with the patient that they're on a certain strength and maybe they're having side effects. So we say, okay, why don't you just cut the

pill in half and see how that works for you? And so they're intentionally taking lower doses than the sig actually says.

So that has been a problem, but there are - I know that there are some programs that some of the pharmacies probably like yourself offer potentially to try the primary nonadherence problem where a prescription is called in and the patient doesn't pick it up. And because we have access to claims data for our at-risk patients and we get them in literally the day or two after the fill takes place, we've actually also thought about doing a primary nonadherence report.

The only tricky thing about the claims is that as soon as the prescription goes over, as you know, the pharmacist fills the prescription and a claim is generated even before the patient has actually picked up the bottle. We have to wait a couple of weeks for you to restock it and send a negative claim back to the health plan saying that it's restocked and erase the original one. It's at that point that we could say, okay, it's been two weeks and the fill was cancelled. That means the patient didn't pick it up. For new prescriptions that might be something that we would actually generate a report that would be useful.

Deirdre Paine: Thank you.

Jessica Moore: This is Jessica, and we have not really worked with community pharmacies. We do have an in-house pharmacy that we're working with, but something that Dr. Garber brought up in his presentation that I would be curious about and wonder from your perspective is that something doable on your end is just checking the blood pressure when they come to pick up their medication and then feeding us that information - could be really useful.

Coordinator: Before we proceed to the next question, as a reminder, please press star, one at this time to ask a question. The next question from Willie Smith of CDC. Your line is open.

Willie Smith: Yes, good afternoon. I have two questions. First is the information given on medication protocols - are there references for that information? I would like to see some references. And no one mentioned lifestyle interventions. Do any of the programs involve lifestyle interventions? Thank you.

Jessica Moore: This is Jessica and I will say we rely heavily on lifestyle interventions. The topic is more medication adherence, but we do do nutrition consultations at the primary care visit and then we also have a nutritionist in house that will do consultations with our patients. We also offer community fitness classes in house and focus on a lot of activity changes also.

Dr. Larry Garber: And this is Larry. We similarly do those, although it's a great idea to offer the actual fitness programs in house. We haven't done that yet.

And in terms of our guidelines, ours are just internally developed by our physicians. And so they're not out there for - on any particular reference.

Dr. Matthew Ritchey: This is Matt. We didn't mention it on this call, but in the formal MMWR and our other work that is packaged with this project we see medication adherence as being an important component of improving blood pressure control overall. But we also know that lifestyle modification is just as important if not more important. One - to prevent hypertension from developing in the first place, but also to help treat hypertension.

So we have materials around that as well on the Million Hearts Web site and within our own division's Web site, the Division for Heart Disease and Stroke Prevention at CDC, around lifestyle modifications, whether it's around exercise and physical activity, around obesity management, and then also around diet particular - focusing on diets that decrease sodium intake and that sort of thing as far as its role in helping improve hypertension and blood pressure control.

So from that standpoint, definitely lifestyle modifications as far as behaviors is an important factor.

And then as far as the question about protocols, within the Millionhearts.hhs.gov Web site we have a lot of additional information on the way protocols can be used within - that have been used with in health systems, and they ways they potentially could be used. So you heard some great examples today on how these specific health systems have lifted protocols that they've slightly modified for the population that they serve. But additionally, within - on the Million Hearts Web site there's other protocols that have lots of evidence behind them about how they've been introduced within health systems and their effect on blood pressure control. So I would encourage you to take a look at those.

Thank you.

Coordinator: Next question is from Dr. Phil Ferrigni from Esse Health. Your line is open.

Dr. Phil Ferrigni: Thank you. I think this is great information. I particularly liked Ms. Moore's emphasis on ninety-day supply. Is there any way we can work with pharmacy benefit managers to encourage the ninety-day supplies? Too many of them just charge three copays for ninety days as opposed to having the copay. There's a material savings in processing, et cetera, when you go from filling three bottles on three different occasions to going to one. And it clearly helps adherence.

Dr. Larry Garber: I second that motion.

Jessica Moore: Me too.

Dr. Matthew Ritchey: So from a CDC perspective this is not - that is definitely one of the groups that we've been reaching out to as far as - what could pharmacy benefit managers and health plans in general be doing in this realm as far as helping improve adherence?

And trying to decrease costs for patients. This idea of - how do we reduce the copays, deductibles that they're being charged, especially for these other things that have been shown to work as far as making it more simple to fill their medications like a ninety-day fill.

So we will definitely echo all of that sentiment and a lot of the work that we've been doing with this groups. So thank you for that suggestion.

Steven Reynolds: Just a reminder to our listeners today, if you have a question please press star, one and get in the queue. While we wait to see if anyone else has any questions, Jessica, let me ask. What was a surprising or the most surprising about the improvement process at Petaluma Health Center?

Jessica Moore: There were several things in terms of things that we heard from the patients that I think were surprising. Some of them were very simple. Like I mentioned adding the sig - to adding the text on what they were taking the medication for to the sig. It was something very easy that we just hadn't thought of as something so significant for patients. It seems obvious to us what the medications are for, but from the patient perspective hearing from them - I have all these bottles of pills and I'm not sure what medications are for what condition. Can you just put it on the bottle?

So things like that were surprising and very simple to do. Overall big picture I think it's sometimes surprising how long it takes to really see the kind of improvements that you want to see, the graph that I showed with over three years. And I think Dr. Garber's graph was over six years. And this kind of improvement is labor-intensive and it doesn't happen right away.

Dr. Larry Garber: This is Larry. Can I say what I've found that was interesting? Or shocking - as we were addressing the issue of hypertension control in general. We were realizing that we were misdiagnosing hypertension in many cases because what we were doing - we were not properly recording the level of control. And the reason is because our nurses

and medical assistants when they put the patient in the room, they take the blood pressure with a regular cuff. And then they were rounding up to the nearest ten. So they were making a seventy-eight into an eighty and eighty-six into a ninety.

And we did a graph of all readings that were done over the course of a year and a histogram showing how many times did someone record a ninety, a ninety-one, a ninety-two, a ninety-three. And there were these huge spikes at the tens.

So what we've done is actually given digital blood pressure cuffs to all of the staff when they're checking the patient, putting the patients in the rooms. And they record them much more accurately now. So we're really dealing with accurate blood pressure readings.

Steven Reynolds: Thank you. That's great information. I don't see any other questions in the queue at this time. So not seeing that, I think before we close today I want our listeners to know that they should please take a moment to look at the next to the last slide. It's slide number forty-two.

On slide forty-two it's the Prevention Status report, or PSR, which highlight for all fifty states and the District of Columbia the status of certain policies and practices designed to address ten public health problems, including heart disease and stroke.

The PSRs pull together information about safe policies and practices in a simple, easy to use format the decision-makers can use to examine their state's status and identify areas for improvement. Look at the bottom of the slide to see all of the PSRs by state or topic.

Speakers, before we close, any final comments?

All right.

Dr. Matthew Ritchey: This is Matt. I just really appreciate all of you taking the time on this important topic to help improve blood pressure control. And I really appreciate our other two presenters for taking the time to share the lessons learned from actually doing the real work at the clinic level. And I really appreciate the guidance and the wisdom that they've shared with us today. So thank you.

Dr. Larry Garber: Thanks for having us.

Jessica Moore: Yes, thanks for having me.

Steven Reynolds: Thank you so much and please stay on the line. And finally, please let us know how we can improve these teleconferences. Email your suggestions to Ostltsfeedback@cdc.gov. That's O-S-T-L-T-S feedback -- all one word -- @cdc.gov.

We hope you'll be able to join us for next month's town hall on Tuesday, October 25, when we will learn more about dental sealant programs in schools. Thank you to our presenters again. You've done a wonderful job. And please stay on the call.

At this time - and thank you to everyone who attended the call. Now I'll turn the call back over to the operator.

Coordinator: Thank you for participating in today's conference. This does conclude the call. You may disconnect at this time.