



Editorial

Pharmacist provision of medication adherence services: More implementation and persistence research needed



Health care stakeholders are increasingly interested in the topic of patient medication adherence as the burden of chronic disease continues to escalate and evidence is showing that improved medication adherence leads to lower overall health care use and costs.¹ Commercial payers, government organizations, and other stakeholders are implementing innovative programs focused on improving adherence. In the United States (U.S.) for example, the Medicare Part D Star Rankings Program is linking quality measures and compensation to medication use and adherence assessments.² In fact, the 3 medication adherence measures are triple weighted.²

Pharmacists have shown in multiple demonstration projects and trials they can provide effective medication adherence services, such as providing dose administration aids, simplifying or synchronizing medication regimens, exploring barriers to adherence using validated tools, or helping patients' link medication taking to daily activities. The majority of pharmacists have long felt assisting patients with medication-related problems and helping improve medication use is an important part of their role.³ Little is known though about current adherence service provision in community pharmacies. What are the facilitators and barriers? Which factors have the most significant impact? Some initial research into candidate factors has been done, with the majority of investigations to date being qualitative.^{4–9} These are ideal for initial exploration and identification of potentially relevant factors, but they cannot provide information about the larger picture nor determine which factors are most influential.

Few cross-sectional survey studies, the next logical step, have been conducted focusing specifically on factors that influence community pharmacist adherence services delivery.^{10,11} Even

though most community pharmacists feel adherence assistance is part of their role, the limited evidence suggests they do not provide appropriate levels of needed adherence services. For example, in a 2004 U.S. study, only 31% of time stressed (stated they needed more time than allocated to provide high quality care) and 52% of non-time stressed pharmacists reported explaining newly prescribed medication administration schedules to patients with HIV/AIDS.¹⁰ Only 1% and 3% respectively always asked their HIV/AIDS patient with a new medication to repeat or rehearse administration instructions.¹⁰ This is strikingly disappointing because good adherence is particularly crucial for HIV/AIDS patients and these are basic adherence support measures. A preliminary study by Mansoor et al¹¹ found that Australian (AU) pharmacists related attempts to identify non-adherence (NA) for only 42% of the prescriptions they dispensed. The follow-up Mansoor et al¹² study, found in this issue of RSAP, supports the finding of low adherence service provision, with pharmacists reporting the use of adherence identification strategies for only 45% of dispensed prescriptions.

Mansoor et al¹² have started the important work of describing the frequency of pharmacist NA identification and services provision. To obtain a fuller picture, additional baseline data must be collected across community health care settings and countries. For example, while 42% and 45% appear low, these may be appropriate once further data is accounted for. As we move forward in this area, consideration also needs to be given as to which definitions of NA and risk for NA should be used, and which NA and risk of NA detection strategies are appropriate. For example the proportion of days covered (PDC), is gaining prominence due to its use as a U.S. Medicare Part D program quality measure. A different

adherence measure, group-based trajectory models, provides medication-use pattern information, which may allow for more targeted interventions.¹³ Additionally, validated questionnaire tools can be quick to administer and can detect adherence barriers beyond access and supply such as side effects, attitudes, or non-typical days.¹⁴ Under which circumstances are these, or other adherence assessment instruments most appropriate? Having easy access to individual patient adherence data has been qualitatively identified as a potential facilitator for adherence service provision.⁴ Clearly being able to identify non-adherers or those at risk of NA is crucial. Mansoor et al¹² found that identifying non-adherers significantly influenced the actual delivery of adherence support. Therefore investigations are needed to determine how NA identification and adherence support software and tools can best be integrated into pharmacy systems and workflow, and if these integrations increase adherence services delivery.

Another important issue is primary NA, in which patients fail to pick up new prescriptions. Could standardized methods of detecting primary NA be developed using electronic prescription order coordination between prescribers' and pharmacies? Any solution to identifying primary NA needs to include physician recommended conditions of use, as many prescriptions are provided for use only if the situation or condition fails to improve or changes in some other way.

Mansoor et al¹² also ascertained the most frequently used adherence support strategies. The most popular was dose administration aids provision, followed by recommending medication management review. The least popular was monitoring total cholesterol in the pharmacy. One adherence support method not identified by Mansoor et al¹² is medication synchronization. This is a promising avenue to explore as it is relatively simple and has the potential to increase PDC and medication persistence significantly. Holdford and Inocencio¹⁵ have identified a thoughtful primary NA research agenda.

The fact that dosage administration aids were the most popular adherence service is interesting, because a 2014 Swiss qualitative study found pharmacists preferred to fill weekly pill organizers in preference to adherence counseling when both were reimbursed at the same rate.⁸ The pill organizer service was described as less complex and more profitable.⁸ This highlights the importance of ensuring reimbursements are commensurate with provision costs and in line

with other profit centers. A recent Scottish study found academicians, health authorities, and others believed pharmacist attitudes and training were the most important factors influencing adherence services provision, while the pharmacists themselves felt remuneration was the most important.⁶ While there are multiple factors influencing its provision, payment for services is clearly an important driver. Work must done to identify what reimbursement levels will sufficiently incentivize pharmacists and pharmacy decision makers to deliver adherence services, and if those providing the reimbursement will obtain value for their investment.

Other factors identified as potential adherence services provision barriers include the ubiquitously discussed lack of pharmacist time and heavy workloads. Qualitatively identified facilitators include having a workflow that already incorporates patient interaction,⁴ and being able to delegate tasks to trained technicians.^{8,16} These qualitative findings are extended by the structural equation modeling (SEM) done by Mansoor et al.¹² SEM compares the impact of multiple factors variance at one time and helps in identifying rational relational models. They found that having enhanced pharmacy services significantly increased the use of NA adherence strategies. They also found that both existing enhanced services and number of full time staff significantly influenced service delivery. Interestingly however, they did not find that time or time pressure, incorporated into their logistics measure, significantly influenced NA identification nor support provision. Further work is needed to identify what pharmacists mean when they say they don't have time. Does it mean that they have inadequate help, inadequate trained help, feel uncomfortable delegating work, that organizational workflow patterns are less than optimal, that they simply don't want to do it, some combination of the above, or yet some other yet unidentified factor?

Finally, the stakeholder/skills construct was identified by Mansoor et al¹² as significantly influencing NA identification. This construct included pharmacist's lack of training, uncertainty in discussing adherence with both patients and physicians, perceptions that adherence was the doctor's role, that doctors were resistant to pharmacist's providing this service, and finally, inadequate clinical patient information. The majority of pharmacists did not have these concerns, but for those who do interventions may be useful. Self-efficacy in regard to communication and skills was also identified in several of the qualitative

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