Medication Adherence for Behavioral Health Providers

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National Council for Behavioral Health
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Welcome!

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Housekeeping

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  ▪ Select “Join by Phone,” then dial the phone number and meeting ID when prompted.

• You will be muted automatically upon entry. Please keep your phone line muted for the duration of the webinar.

• Webinar is being recorded and will be archived for future viewing at www.pcssNOW.org within 2 weeks.

• Submit questions in the Q&A box at the bottom of your screen.
Disclosures

Dr. Joe Parks has provided consulting services with Otsuka in the past 12 months.
Target Audience

The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.
Educational Objectives

• At the conclusion of this activity participants should be able to:

  ▪ Discuss the concept of medication adherence and non-adherence
  ▪ Describe medication adherence challenges for each of the major medications used to treat substance use disorders
  ▪ Demonstrate ways in which prescribers, treatment teams and organizations can improve workflows and strategies for increasing medication adherence with their patients
  ▪ Review the role of non-prescribing staff in engaging patients on medication adherence
  ▪ Recognize the challenges of medication adherence for patients with substance use disorders and other co-morbid conditions.
Poll #1

To what degree is medication adherence a problem in your organization?

a) Urgent problem
b) Important
c) Moderate
d) Somewhat of a problem
Poll #2

How challenging is it to ensure that patients adhere to their medication regimen?

a) Very challenging
b) Challenging
c) Moderately challenging
d) Somewhat challenging
e) Not challenging
Why Focus on Medication Adherence

- Non-adherence to medications is prevalent and leads to poor outcomes
- For patients prescribed buprenorphine, the adherence rate is 37% - 41%
- For patients prescribed methadone, the adherence rate is 83%
- For patients diagnosed with bipolar disorders, the average rate of non-adherence is 40%
- Poor patient outcomes can include:
  - Relapse
  - Delays in achieving remission
  - Violence, such as reported aggression and arrests
  - Suicide
  - Premature death

[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6165853/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6165853/)
[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5773191/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5773191/)
National Council Medical Director Institute

- Medical directors from mental health and substance use treatment organizations from across the country.
- Advises National Council members, staff and Board of Directors on issues that impact National Council members’ clinical practices.
- Champions National Council policy and initiatives that affect clinical practice, clinicians employed, by member organizations, national organizations representing clinicians and governmental agencies.
The Psychiatric Shortage
Causes and Solutions
March 29, 2017 | Updated March 1, 2018

Medication Matters
Causes and Solutions to Medication Non-Adherence
July 2018
Expert Panel

Practitioners
Pharmacists
Administrators
Patients/Peers
Researchers
Advocates
Payers
Policymakers
Adherence to Medications

“No medication works inside a bottle. Period.”
— C. Everett Koop, MD

“Drugs don't work in patients who don't take them.”
— C. Everett Koop, MD
Average Rates of Medication Non-adherence

- HIV: 13.0%
- Hypertension: 19.0%
- Alcohol Misuse/Dependence: 35.0%
- Bipolar: 35.5%
- Diabetes: oral meds: 35.5%
- ADHD: 37.0%
- Diabetes: insulin: 37.0%
- Coronary Heart Disease: 45.0%
- Schizophrenia: 45.0%
- Asthma: 50.0%
- Anxiety Disorders: 57.0%
- Major Depression: 60.0%
Adherence Metrics: MPR

Table 1

Rates of adherence over 12 weeks according to various methods among 52 outpatients with schizophrenia

<table>
<thead>
<tr>
<th>Assessment method</th>
<th>Total N</th>
<th>N</th>
<th>%</th>
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<tbody>
<tr>
<td>Self-report</td>
<td>50</td>
<td>43</td>
<td>86</td>
</tr>
<tr>
<td>Physician impression</td>
<td>50</td>
<td>33</td>
<td>66</td>
</tr>
<tr>
<td>Pill count</td>
<td>51</td>
<td>38</td>
<td>75</td>
</tr>
<tr>
<td>Electronic monitoring</td>
<td>52</td>
<td>33</td>
<td>63</td>
</tr>
<tr>
<td>Variability of antipsychotic plasma level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Across 72 hours at the end of the study</td>
<td>46</td>
<td>29</td>
<td>63</td>
</tr>
<tr>
<td>Across the study period</td>
<td>45</td>
<td>22</td>
<td>49</td>
</tr>
</tbody>
</table>

*Electronic monitoring data were missing for one participant who consistently left the top off the pill container. One individual received drug samples, so the pill count could not accurately be computed. Complications in blood collection resulted in missing data for seven patients at 12 weeks and eight patients across time. Data for self-report and physician report at 12 weeks were not collected for two individuals.*

*If the difference between antipsychotic plasma levels was more than 30%, patients were considered to be nonadherent.*

Consequences of Non-adherence

Failure to take medication as prescribed:

- Causes 10% of total hospital admissions
- Causes 22% of nursing home admissions
- Has been associated with 125,000 deaths
- Consequence of non-adherence to methadone and buprenorphine is overdose
- Results in $100 billion/year in unnecessary hospital costs
- Costs the U.S. economy $300 billion/year

Consequences of Non-adherence

• Lack of progress toward goals/recovery
• Polypharmacy
• Unnecessarily high doses
• Illness progression and relapse
• Increased utilization of the ER and hospital
Patient-Reported Barriers to Adherence with Antipsychotic Medications*

Percentage of Patients Reporting Barrier

- Stigma
- Adverse drug reactions
- Homelessness/Substance misuse
- Memory problems
- Lack of social support
- Afraid of medication
- Denial of illness
- Lack of trust in provider
- Difficulty with regimen

*In patients with schizophrenia.

Adherence is Related to Dosing Frequency

Perspectives that Impact Adherence

- Social determinants of health
- Clinic location and hours
- How medications are administered
- Mental illness
- Desire to continue to use illicit drugs

Clinician Factors—Communication

- Clinician-patient relationship may impart the most value in improving adherence.
- Key elements are trust and caring.
- Promoting participation in decision making.
- Positive expectancy/hope.

The Clash of Perspectives

“…my psychiatrist said I was getting better, but I experienced being disabled by the medication. He said I was more in control, but I experienced the medication controlling me. He said my symptoms were gone, but my experience was that my symptoms were no longer bothersome to others but some continued to torment me.

…I lost years of my life in this netherworld, and although I was treatment compliant and was maintained in the community, I was not recovering.”

Pat Deegan

<table>
<thead>
<tr>
<th>I feel sedated.</th>
<th>You are not psychotic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I’m still hearing distressing voices.</td>
<td>You are not shouting at your voices anymore.</td>
</tr>
<tr>
<td>I can’t think clearly on this medicine.</td>
<td>You are not thought disordered.</td>
</tr>
<tr>
<td>I feel like the meds are controlling me.</td>
<td>You are more in control.</td>
</tr>
<tr>
<td>I’m not myself when I’m on this medicine.</td>
<td>You have returned to baseline.</td>
</tr>
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</table>
**Person-centered Care**

**Person-centered care** (or treatment) is care or treatment that is based on the goals of the individual being supported, as opposed to the goals of the system or as defined by a doctor or other professional.
Person-centered Care

It is more important to know what manner of patient has the disease, than to know what manner of disease the patient has.

Sir William Osler
Shared Decision-making

Moving from medication “compliance”

Patients’ passive following of provider orders

Making collaborative treatment decisions jointly based on patient’s lived experience and choice
Steps to Shared Decision-making

1. Choice Talk → help patient to understand that choices exist and that they are invited to participate in making decisions related to their treatment.

2. Option Talk → provide more information about treatment options available, including pros, cons, benefits and harms related to each. Ensure that the patient understands the options.

3. Decision Talk → support the patient’s consideration of preferences in deciding what is best for them.

Shared Decision-making

https://mat-decisions-in-recovery.samhsa.gov/
DYSFUNCTION

The Only Consistent Feature of All of Your Dissatisfying Relationships is You.

www.despair.com
DO NOT...

...overemphasize the dangers of combining prescription medication with alcohol and drugs.

- Most combinations are not dangerous except benzodiazepines.
- Most patients have used while on medication without ill effects. They will conclude you are either a liar or a fool.
- Most patients will stop prescription medication and continue to use alcohol and drugs.
- If they are going to be intoxicated, it’s better not to be psychotic too.
Unrealistic Expectations Cause Dissatisfaction

Unrealistically high expectations for medication encourage:

• Premature switching of medications
• Polypharmacy
• Non-adherence

Do not overstate benefits; instead, say:

• “70% of people get 70% better.”
• “You are likely to feel better but will still have some remaining symptoms.”
• “Most people have some side effects.”
• “Medication will not fix everything.”
• “If we keep adding meds to fix every last symptom, you will end up on so many that you will get the staggers.”
General Approach

The approach when talking with patients about medication is the same as when talking about their substance use decisions:

• Explore the triggers or cues that led to the undesired behavior (either taking drugs of abuse or not taking prescribed medications).
• Review why the undesired behavior seemed like a good idea at the time.
• Review the actual outcome resulting from their choice.
• Ask if their choice got them what they were seeking.
• Strategize with patients about what they could do differently in the future.
Getting Started

Take 5-10 minutes every few sessions to go over these topics with your clients:

- Remind them that taking care of their behavioral health will help prevent relapse.
- Ask how their medication is helpful.
- Acknowledge that taking a medication everyday is a hassle.
- Acknowledge that everybody on medication misses taking it sometimes.
• Do not ask if they have missed any doses; rather ask, “How many doses have you missed?”

• Ask if they felt or acted different on days when they missed their medication.

• Was missing the medication related to any substance use relapse?

• Without judgment, ask, “Why did you miss the medication? Did you forget or did you choose not to take it at that time?”
For patients who forgot, ask them to consider the following strategies

• Keep medication where it cannot be missed: with the TV remote control, near the refrigerator, or taped to the handle of a toothbrush. Everyone has 2 or 3 things they do everyday without fail. Put the medication in a place where it cannot be avoided when doing that activity, but always away from children.

• Suggest they set an alarm clock for the time of day they should take their medication. Reset the alarm as needed.

• Suggest they use a Mediset®: a small plastic box with places to keep medications for each day of the week, available at any pharmacy. Mediset® acts as a reminder and helps track whether or not medications were taken.

• For patients receiving methadone: keep a calendar, plan for emergencies, or take-home doses.
For patients who admit to choosing NOT to take their medication

- Acknowledge that they have a right to choose NOT to use any medication.

- Stress that they owe it to themselves to make sure their decision is well thought out. It is an important decision about their personal health, and they need to discuss it with their prescribing physician.

- Ask their reason for choosing not to take the medication.
For patients who admit to choosing NOT to take their medication

• Don’t accept “I just don’t like pills.” Tell them you are sure they wouldn’t make such an important decision without having a reason.

• Offer examples of reasons why others might choose not to take medication. For instance, they:
  - Don’t believe they ever needed it; never were mentally ill
  - Don’t believe they need it anymore, cured
  - Don’t like the side effects
  - Fear the medication will harm them
  - Struggle with objections or ridicule from friends and family members
  - Feel like taking medication means they’re not personally in control
Assume that all patients will choose to stop taking a medication eventually

- “Everybody decides not to take their meds at some point, usually to see if they still really need them.”

- “I assume that you will too, so please tell me so I can help you be successful with how you stop them.”

- “I recommend only stopping one med at a time, not all at once.”

- “I recommend tapering meds slowly to avoid withdrawal effects.”

- “Write down your 3 early warning symptoms of relapse on 3 index cards: you keep one, give me one, give one to a friend you see a lot and let’s all watch out for relapse symptoms… i.e. treat it like an experiment!”
Offer more than meds –
Encourage Self-Management and Recovery

“When meds have done as much as they can for you…

• “What can you do for yourself to get better?”
  ▪ Social interaction
  ▪ Physical activity
  ▪ A regular schedule
  ▪ Changing habits that make you unsatisfied

• “How can you get on with having the kind of life you want in spite of your remaining symptoms?”
  ▪ “It’s better to go out and pursue your desires with symptom X than to sit at home waiting for symptom X to go away.”
  ▪ “You deserve better.”
  ▪ “Don’t let this disease define who you are and what you do.”
  ▪ “There is more to life than managing your illness.”
I CAN'T STOP DREAMING ABOUT WORK.

AND I USUALLY SLEEP AT WORK, SO I'M DREAMING ABOUT SLEEPING AND IT'S FREAKING ME OUT.

HAVE YOU CONSIDERED DOING WORK?

I WANT PILLS, YOU QUACK.
Organizational Toolkit on Medication Adherence
Practitioner Focus

• Identify effective ways to engage clients in making informed decisions and use their medication in a safe and effective manner
• Understand barriers and challenges that contribute to non-adherence
• Assess medication adherence and treatment planning practices
• Implement strategies and best practices to promote medication adherence
Practitioner Focus

- Strengthen the therapeutic relationship
- Assess factors related to medication non-adherence
- Review populations at higher risk for non-adherence
- Measuring and monitoring individual-level medication adherence
- Interventions to support medication adherence
- Treatment planning
- Engage in organizational workflows and strategies
Organizational Improvement Goals

- **INCREASE THE MEDICAL AND BEHAVIORAL HEALTH PROVIDERS’ KNOWLEDGE ABOUT THE PREVALENCE AND IMPACT**

- **STRENGTHEN THE PATIENT-PRACTITIONER RELATIONSHIP THROUGH A SHARED DECISION-MAKING PROCESS**

- **ASSESS THE PATIENT-SPECIFIC BARRIERS CONTRIBUTING TO NON-ADHERENCE**

- **DEVELOP AND IMPLEMENT A PLAN TO ADDRESS THESE FACTORS**

- **EVALUATE AND MONITOR IMPROVED ADHERENCE AND HEALTH OUTCOMES THROUGH DATA-DRIVEN DECISION-MAKING**
Power of Team-based Care

• Shared understanding of the principles and practices
• All staff across the organization should be trained (front office staff, prescribers, case managers)
• Use of ongoing staff training in risk assessment, trauma informed care, motivational interviewing, and positive behavioral communication
• Engage and employ peer support workers
Quality Improvement

- Collect and analyze population-based data
- Identify and monitor high-risk groups
- Use of data-driven care
Data-driven Care: Process-related Performance Indicators

- % of patients who have been assessed for MA
- % of patients assessed to be significantly non-adherent
- % of patients who are non-adherent who have a treatment plan in place with a goal around MA
- % of staff who have been trained in best practices to promote adherence
Data-driven Care: Outcome-related Performance Indicators

- Patient report/
  Measures of functioning

- Reduction in ER and hospital usage

- Clinical symptom measures

- Pill counts, prescription refills, blood chemistry and urinalysis
References

• N Engl. J Med 8/4/05, National Pharmaceutical Council, Archives of Internal Medicine, NCPIE, American Public Health Association
Thank You!

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PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.

- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medications for addiction treatment.
  - 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
  - No cost.

For more information visit: [https://pcssNOW.org/mentoring/](https://pcssNOW.org/mentoring/)
PCSS Discussion Forum

Have a clinical question?

Ask a Colleague
A simple and direct way to receive an answer related to medication-assisted treatment. Designed to provide a prompt response to simple practice-related questions.

Ask Now

http://pcss.invisionzone.com/register
**PCSS** is a collaborative effort led by the American Academy of Addiction Psychiatry (AAAP) in partnership with:

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<th>American Society of Addiction Medicine</th>
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<td>Association for Multidisciplinary Education and Research in Substance use and Addiction</td>
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<tr>
<td>American Academy of Pediatrics</td>
<td>Council on Social Work Education</td>
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<td>American Pharmacists Association</td>
<td>International Nurses Society on Addictions</td>
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Educate. Train. Mentor

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