

Maximizing Pharma's Adherence Dollars



Adherence May Be Just What the Doctor Ordered... for the Patient, the Doctor and Pharma

In today's marketplace, adherence solutions are often based on one-size-fits-all thinking. The results of these efforts have been lackluster. A new way of thinking about adherence – by identifying and effectively addressing the barriers – is what's needed to solve this burgeoning problem.

BY PAUL LEVINE

Many pharmaceutical product launches would make for textbook examples of successful marketing promotional campaigns. In fact, the industry's success over the past few decades was built on the foundation of multi-channel, multi-million dollar product launches. Typically, pharmaceutical companies spend 97 percent of their marketing budgets to capture initial market share. Over the last decade, \$100 million has been invested on a typical product launch, which includes both consumer and professional promotional campaigns.

However, keeping those newly acquired patients adherent to their prescribed treatment and heading to the pharmacy for medication refills gets little attention or investment. Brand teams historically have focused their energies on acquiring new patients and prescriptions, rather than offering real support to patients who have a prescription in hand and encouraging their adherent behavior. Reasons for this may vary: Little glamour is associated with developing an adherence program and few solutions have proven to deliver sure, quick and easily measurable success.

In fact, adherence solutions currently offered in the marketplace are often based on the assumption that one size fits all patients, all conditions, and all drugs. Reminder calls, loyalty cards and “intelligent” packaging are just some of the accepted

tactics often deployed to try to encourage patients to refill and stay compliant with the doctor's prescribed treatment – even if a reminder isn't what stands in the patient's way to being adherent. Success is mixed and likely reaches those who might already be easily convinced to stay adherent – the “hand raisers.” Reaching the typical patient and identifying and effectively addressing their barrier to adherence is much more challenging and requires a new, more strategic approach.

Economic statistics tell the story

It is getting harder and harder for the industry to ignore the daunting statistics showing the impact of poor patient adherence:

- 33 percent of prescriptions are never filled by patients
- 50 percent of people with chronic conditions are non-adherent
- Medication non-adherence costs \$177 billion annually in the U.S.

In addition, the recent economic downturn is introducing additional challenges to patient adherence. A 2009 survey of pharmacists conducted by the American Pharmacists Association found that more than half of the pharmacists believe patients have altered their adherence to their previous medication regimen (split tablets, skipped doses). According to four in

10 pharmacists, patients have also postponed medical procedures, stopped taking medicines, or turned to physician samples in lieu of filling their prescriptions. Clearly, adherence solutions aren't doing enough to identify patient's very real barriers to treatment adherence.

The benefits of improved adherence can't be ignored.

Although addressing adherence may seem more difficult – and less glamorous – I would contend that solving it provides a unique opportunity to help patients, support physicians, and benefit the pharma industry as well. If managed well, the pharmaceutical manufacturer can not only expect to see a return on its investment in adherence with increased sales, it also has the potential to win back goodwill and a more favorable public image.

The solution? Not one, but many

Few would argue the point that improving patient adherence is desirable and beneficial. However, one of the rarely noticed points about adherence is that the challenge itself is multi-factorial and resistant to one-size-fits-all solutions. Consider the following situations and how different the appropriate adherence solutions are. Are they all dealing with adherence? You decide:

- Consider a typical adherence problem – forgetting. For patients who regularly forget to take their medications, reminder call and/or packaging-based approaches to improving adherence are quite viable. But what of patients who can't afford the copay for a product and therefore don't even fill the prescription? Will a reminder approach work? Not a chance.
- For these patients, the solution often turns out to be an Rx card, dollars-off-copay approach. And the solution works well – assuming the financial offset is sufficient. (We had experience with a program for a very high-cost product in which a one-time \$150 copay offset was offered. However, physicians were highly reluctant to prescribe the product over the long-term, fearing that after that first month, patients would not be able to afford the product.)
- Then there are products in which there are “structural issues” surrounding adherence. For example, some products prescribed in the inpatient setting by hospital-based physicians work wonderfully, but if the importance of continuing to use the product once the patient is ambulatory never gets conveyed to the treating physician in the community, then there's no benefit conferred. The solution in such a case may actually rest with the discharge planner.
- Finally, there are situations in which learning theory and behavior change solutions are key. In these situations, adherence problems rest on some combination of the constellation of factors contributed by the patient, the product, the therapeutic class, and even the physician. For these

products, sophisticated patient segmentation methods and interventions work best by creating tailored solutions specific to the needs of each cluster of patients.

The key point to this review is that each product and its associated adherence challenge may be highly divergent – yet all may still describe their problem as “adherence.” Thus, crafting effective solutions may often require a fair amount of analysis in order to understand what the “real” adherence issue is.

Some products, therapeutic classes Fit better than others

Notwithstanding all the caveats above, there are clearly some drug classes and products that may make better economic sense (for addressing the adherence issue) and help to focus the industry's investment of energy and budget dollars. For example, the easiest economic arguments can be made for investing in adherence solutions for products in the following classes:

1. High-priced products which represent a significant loss to the manufacturer if a patient is non-compliant, even for one month. Typically, high-cost injectables and/or biologics fall into this class.
2. High-use products which generate considerable patient volume represent a different cluster of potential classes. This cluster includes products where the underlying prevalence of the condition is relatively high (e.g., hypertension, cholesterol, type 2 diabetes, etc.) What these products lose in per-month costs can be more than offset by huge volumes of patients.
3. Classes of medications which treat severe illnesses and where the costs – economic or otherwise – of non-adherence are significant (cancer or HIV for example) are also good candidates. In these classes, physicians are also highly tuned in to their patients' treatment, which makes their involvement in adherence efforts easier.

Pharmaceutical companies should have the benefit of learning from clinical trials and early studies and be able to anticipate particular treatment challenges to their medication. Expected barriers to the particular medication, including anticipated side effects, patient tolerability, convenience of dosing, and patient comprehension can then be built into the program proactively.

Two programs addressing different issues related to the use of dyslipidemic medications illustrate how the different needs of the products yielded very different solutions.

- Two niacin-based cholesterol reducing medications were typified by significant and disconcerting flushing side effects. The side effect was transient but appeared suddenly and caused not only immediate patient drop-off, but prescribing drop-off as well, as physicians grew less interested in prescribing the products to their patients. The manufac-

turer initiated a prospective educational campaign for patients, designed to inform them about the potential side effect – before they even filled the initial prescription. It effectively engaged the patients with targeted communication strategies and offered copay assistance as well as ongoing support to keep them on track with their medication. The results? Significant reductions of 26 percent in drop-off after only one month and a more loyal physician and patient population. One physician even chose to hold educational classes in the office based on the program material for patients prescribed the medication.

- Another dyslipidemic medication chose a different approach. This product focused on more traditional patient-based issues surrounding high cholesterol (e.g., diet, weight, exercise, etc.) Additionally, the manufacturer chose to include feedback from patients on their overall experience taking the medication. This insight turned out to be quite significant once the financial analysis was conducted since it revealed that not only were individual patients’ level of persistency increased significantly relative to comparable patients unexposed to the intervention (see Figure X), but physicians’ initial prescribing of the product also increased! (See Figure Y).

The impact on individual patient persistency increased by 42 days over just six months. Note as well, that almost half of all patients (44%) in the program were still filling six or more prescriptions – compared to only 18% of patients unexposed.

This represented a 10.3 percent incremental lift in NRx for the physicians engaged in the program relative to matched control physicians. What was responsible for the NRx impact on physicians of a program focused on encouraging the individual adherence of patients? While it is hard to be conclusive, it seems that the most likely reason is the raised awareness of the program’s existence in the physician’s mind. In other words, the program itself – indeed, even the *awareness* of the existence of the program – created a sense of a “safety net” for that physicians’ patients, the idea that once prescribed the product, these patients would not be “left alone” to fend for themselves.

Two dyslipidemic products, two very different approaches.

DTC/CRM helps find the pain points

The DTC marketer can contribute to the effort of getting patients on the path to medication adherence. Dialogue established early on with the interested patient and

continued through CRM program communications can support ongoing identification of patient segments, barriers to adherence, and gaps in treatment education.

Once a patient has expressed interest in a potential treatment, the pharmaceutical company can begin to create communications and gain a deeper understanding of the patient’s past medication behavior, demographics, education about their condition and motivation. The plan won’t work if all patients are thrown into a standard stream of communications – general patient education, refill reminders, brand loyalty coupons and the like. Segmented messages should be deployed which will capture the patient’s attention, gain trust and begin to build a long-term adherence plan suitable for the individual’s needs and challenges.

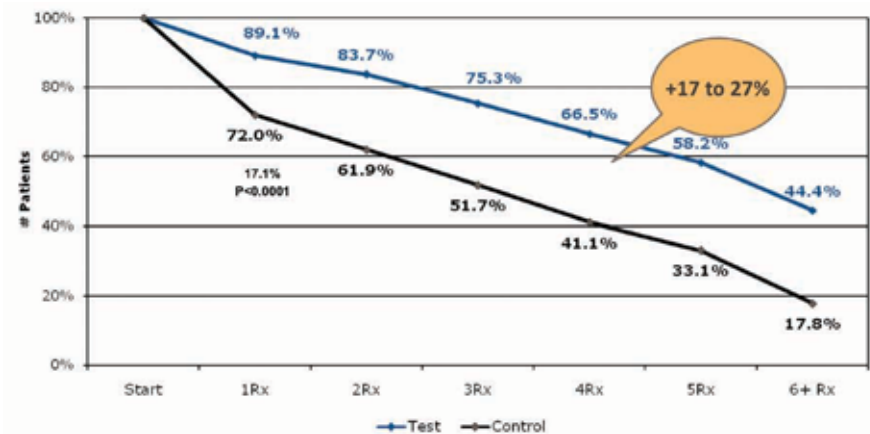
Be creative and engage patients Through multiple on-ramps

Consumers are increasingly active in their searching and decision making about their healthcare. Pharmaceutical brands can help them find the guidance and tools to support treatment adherence at those critical decision making times.

But just as consumers have individual barriers to treatment, they also may seek their answers through different channels. In order to maximize the success of outreach and reach beyond the “hand raisers,” brands should consider creative new channels and messages to bring patients on board. The brand Web site is an obvious channel, but the information offered there must be engaging, helpful and offer quick access to their answers, even if it means presenting product side effects in a straight-forward fashion. Beyond the brand Web site, brands can engage patients at various patient social networking sites,

Figure X: Impact on Individual Patient Adherence

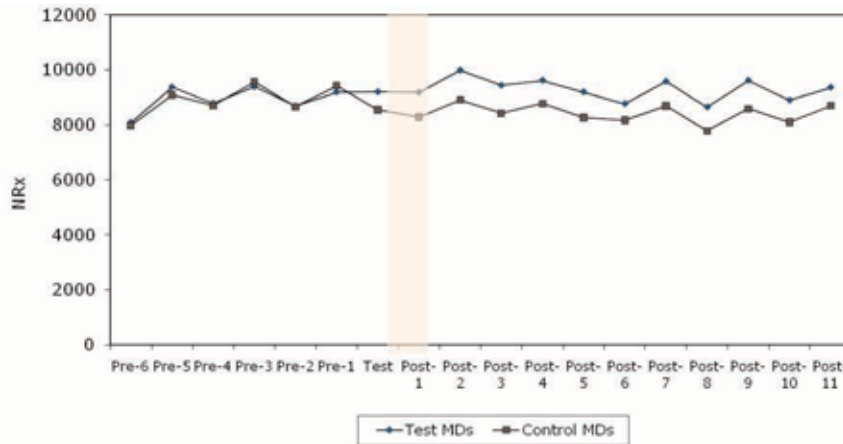
Continuing User Lapse Rate and Fill Decay Curve



P-values were determined using Pearson’s chi square test for conversion and t-tests for adherence. If conversion counts were below 5 then Fisher’s exact test was used.

Figure Y: Program MDs Increased Their Prescribing of the Target Medication by 10.2% Relative to Matched Controls

During the eleven-month post period, Test physicians prescribed 10.2% more NRxs compared to Control physicians. This change in prescribing behavior is statistically significant (cl=99.99%).



Note: cl = Confidence level; if cl >= 90% the program impact is significant, else it is directional. Analysis conducted : ANCOVA.

including WebMD, patientslikeme.com, as well as condition-specific sites, and invite them to join a CRM-type adherence program.

Additional tools and invitations can be offered to the patient and to the caregiver at the doctor’s office, pharmacy and, for chronic conditions, through such healthcare communications vehicles as member newsletters. Information can be non-promotional to your specific brand, but offer helpful guidance on treatment adherence to the particular condition.

Where do doctors fit in the solution?

Integrally, if possible. But a fair discussion of the physician’s role in encouraging adherence must include a few sobering facts – not the least of which is that most physicians generally don’t see adherence as part of their portfolio. Considering the increasing pressures on their time with patients, physicians aren’t likely to be interested in a program that requires additional burden on them or on their office staff. However, we know that physicians can have an enormous influence on their patients’ decision-making and that they want to see their patients achieve positive treatment outcomes. Consequently, the ideal solution needs to maximize the physician’s *influence*, while minimizing the amount of physician *time*.

There are lessons to be learned from other segments in health care. Years ago, when the managed care industry began focusing on reducing the lengths of hospital stays, it learned something very important. While initially, it needed to actively manage these lengths of stay (for example, “20 days in the hos-

pital is not necessary, four days is”), over time physicians began policing themselves and began asking for lengths of stay that would be authorized as necessary. This effect, nicknamed “the sentinel effect,” applies to adherence solutions, as well – only in reverse.

With adherence, physicians effectively begin to become more comfortable with individual medications once they know that there are programs in place to support their patients. (Consider the results of the second dyslipidemic agent described above.) In order to involve the physician without interfering with the busy practice, an adherence solution needs to keep the physician informed about their patient’s progress as quickly and as systematically as possible. In this way the adherence program becomes a complement to the care provided by the physician – not a replacement. Indeed the opportunity to provide net-new information to the physician is a significant value-add for the physician, allowing for more effective communication between patient and doctor, so the two can work together to address identified barriers or applaud success.

Summarizing the issues, solutions

Medication adherence is a challenge that has stymied patients, physicians, pharmaceutical companies and policy planners ever since patients were prescribed medications. Consequently, it’s important to recognize that if approaches to improving medication adherence can make incremental progress, that in itself would be a good thing! But as the discussion above has outlined, it’s critically important to assess accurately what the issue are regarding adherence for an individual product since the nature of the problem can lead to many different solutions.

However, if this hurdle is effectively jumped, then the benefits that accrue to all the major constituents will be sizable:

- The patient will take the product regularly and as directed.
- The physician will feel more comfortable prescribing certain types of products, knowing that patients will be supported on their treatment journey.
- The pharmaceutical company will generate increased product use both in new prescriptions and refills. **DTC**

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