Medication Adherence for Behavioral Health Providers

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National Council for Behavioral Health
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Welcome!

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- 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

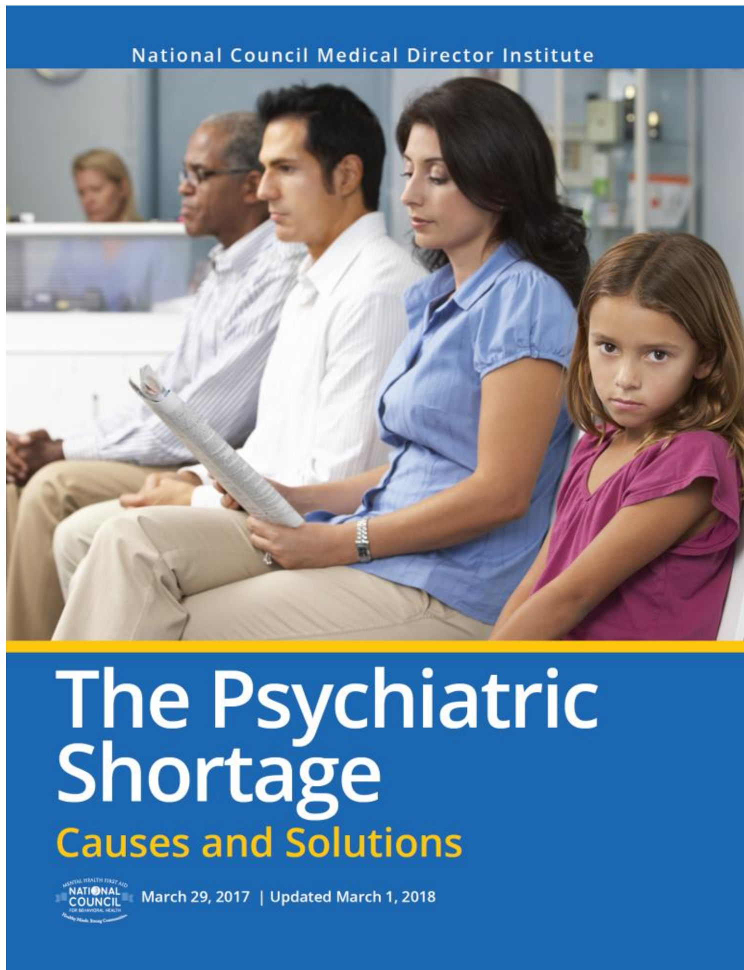
- Non-adherence to medications is prevalent and leads to poor outcomes
- For patients prescribed buprenorphine, the adherence rate is **37% - 41%**
- For patients prescribed methadone, the adherence rate is **83%**
- For patients diagnosed with bipolar disorders, the average rate of non-adherence is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

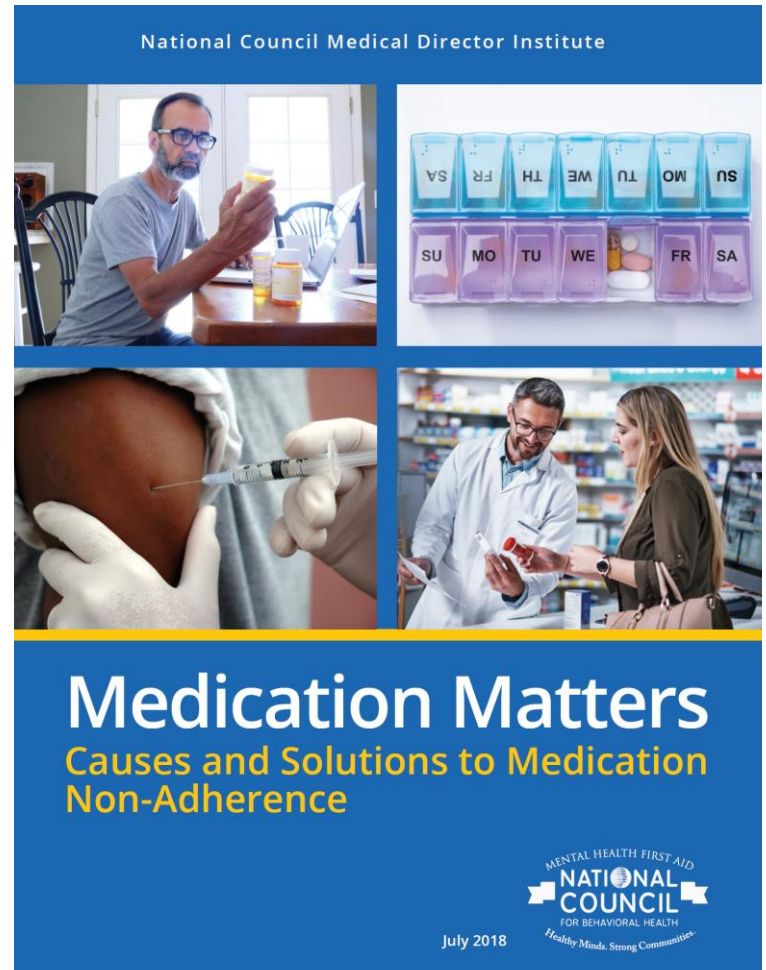
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6165853/
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5773191/

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 Response





Expert Panel

Practitioners
Pharmacists
Administrators
Patients/Peers
Researchers
Advocates
Payers
Policymakers

Adherence to Medications

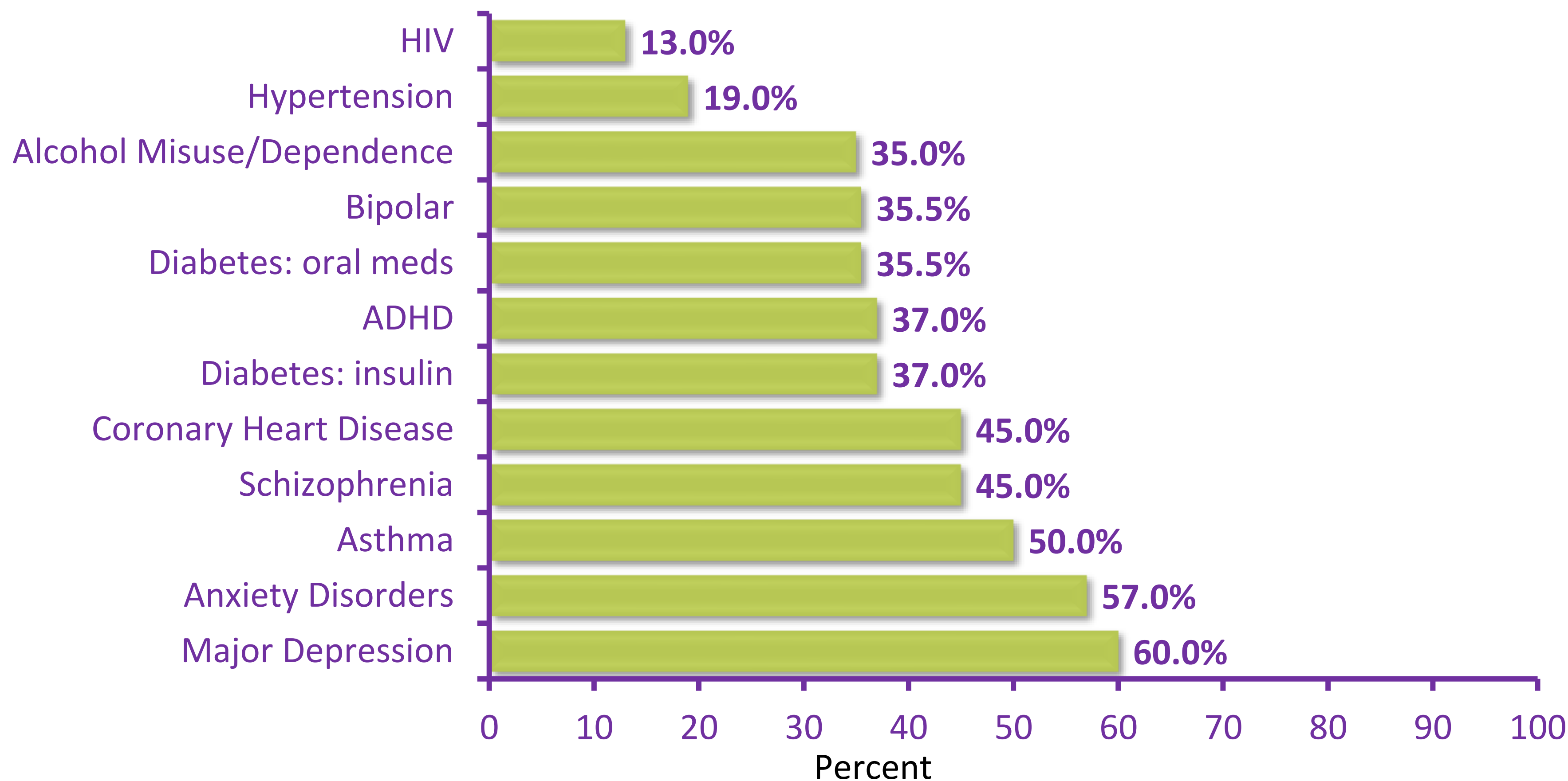
“No medication works inside a bottle. Period.”

— 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



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Adherence Metrics: MPR

Table 1

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

Assessment method	Total N	N	%
Self-report	50	43	86
Physician impression	50	33	66
Pill count	51	38	75
Electronic monitoring	52	33	63
Variability of antipsychotic plasma level[b]			
Across 72 hours at the end of the study	46	29	63
Across the study period	45	22	49

[a] 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.

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

Velligan DI, Wang M, Diamond P, et al: Relationships among subjective and objective measures of adherence to oral antipsychotic medications. Psychiatr Serv 2007;58:1187-1192.

Consequences of Non-adherence

Failure to take medication as prescribed:

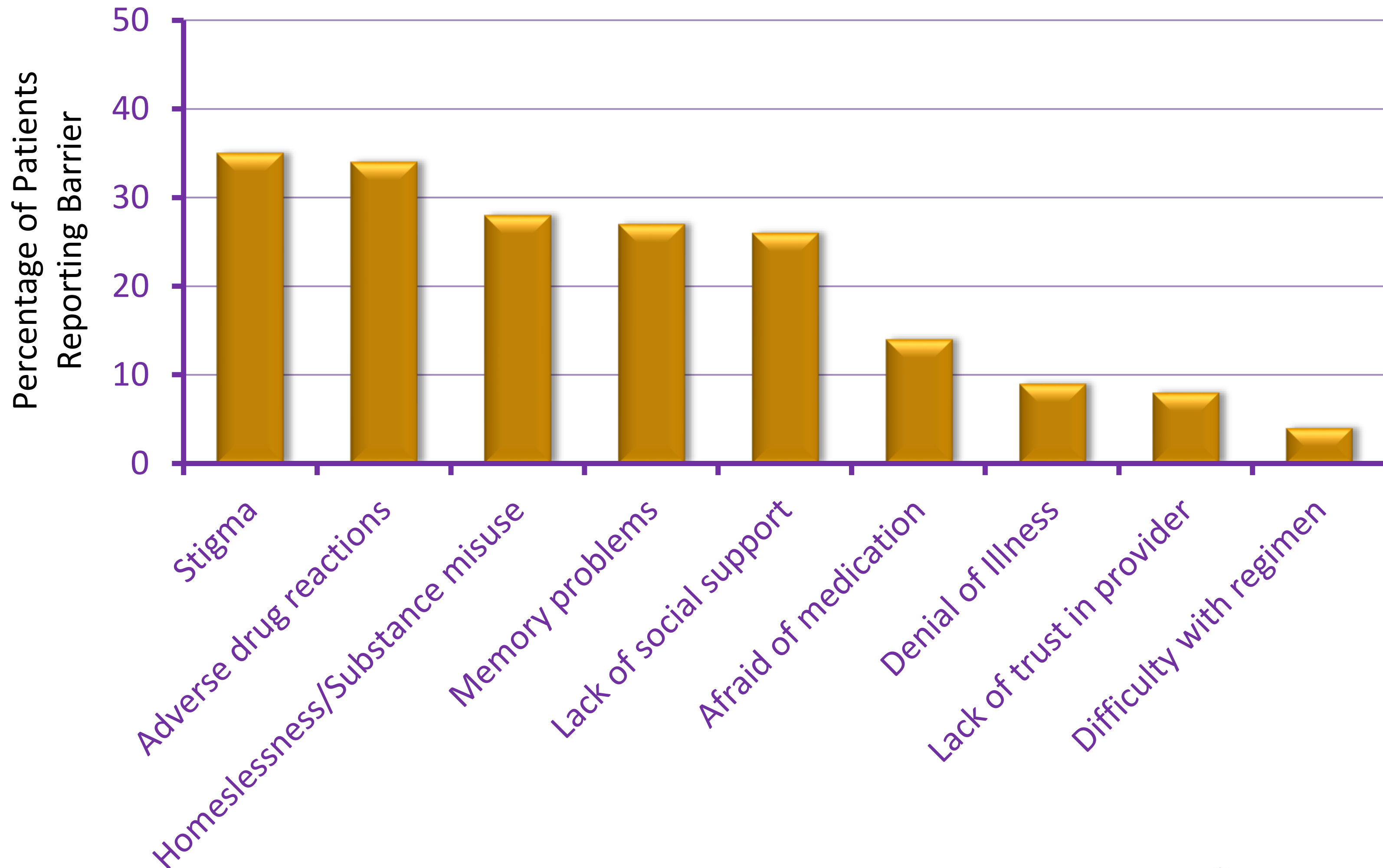
- Causes **10%** of total hospital admissions
- Causes **22%** of nursing home admissions
- Has been associated with 125,000 deaths
- Consequence of non-adherence to methadone and buprenorphine is **overdose**
- Results in **$100 billion/year** in unnecessary hospital costs
- Costs the U.S. economy **$300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

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

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*



*In patients with schizophrenia.
Hudson T et al. *J Clin Psych*. 2004; 65:211-216.

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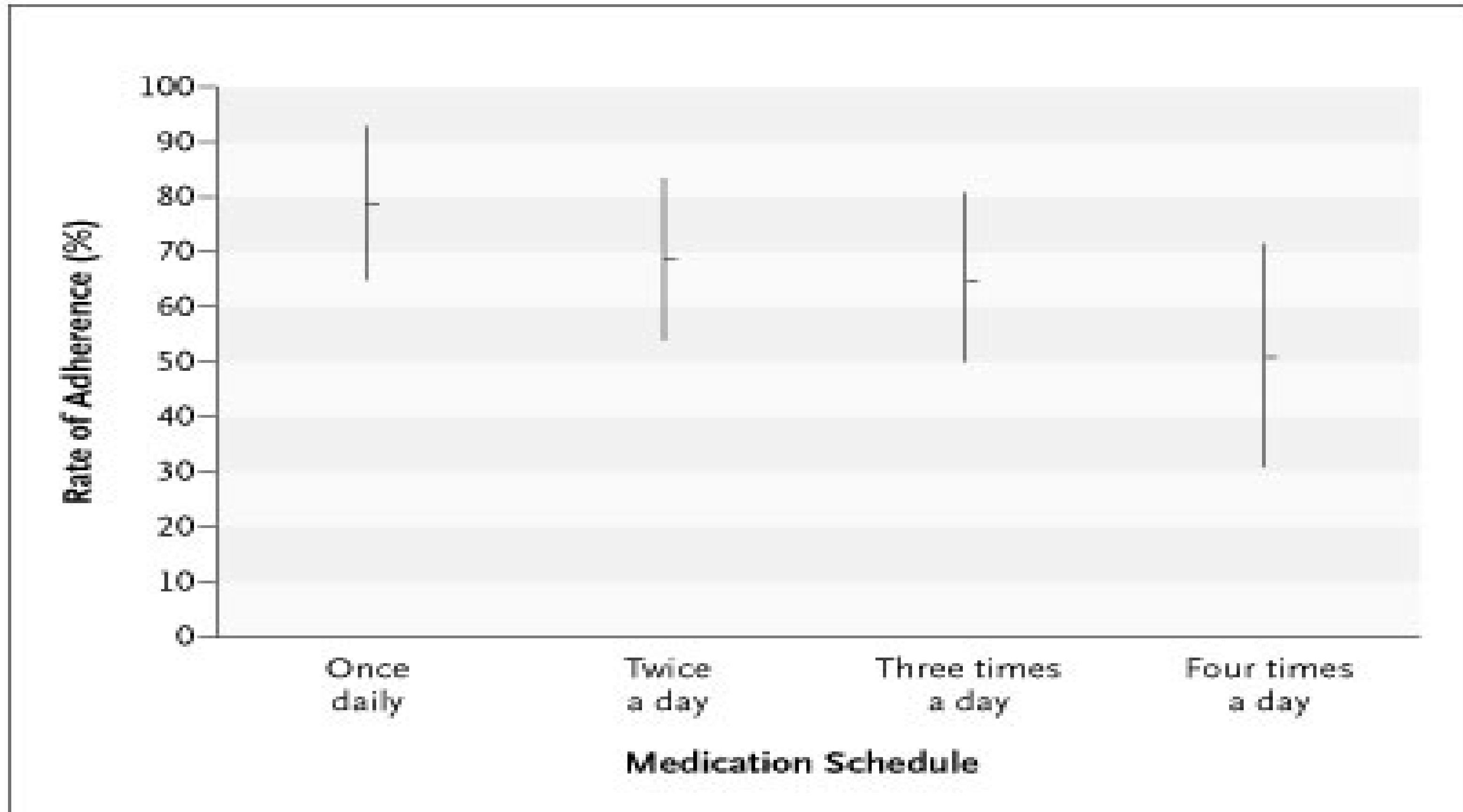
Adherence is Related to Dosing Frequency



Osterberg L. et al. *New Eng J Med.* 2005; 353:487-497.

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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

https://ascpjournal.biomedcentral.com/articles/10.1186/s13722-019-0139-3

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.

Cruz M, et al. *Psych Svc.* 2002; 53:1253-1265.
Dearing K, et al. *Psych Nurs.* 2004; 18:155-163.

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

Deegan, P. E. (2007). The lived experience of using psychiatric medication in the recovery process and a shared decision-making program to support it. *Psychiatric Rehabilitation Journal, 31*(1), 62-69. doi:10.2975/31.1.2007.62.69

Pat Deegan: The Clash of Perspectives

I feel sedated.	You are not psychotic.
I'm still hearing distressing voices.	You are not shouting at your voices anymore.
I can't think clearly on this medicine.	You are not thought disordered.
I feel like the meds are controlling me.	You are more in control.
I'm not myself when I'm on this medicine.	You have returned to baseline.

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

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Steps to Shared Decision-making

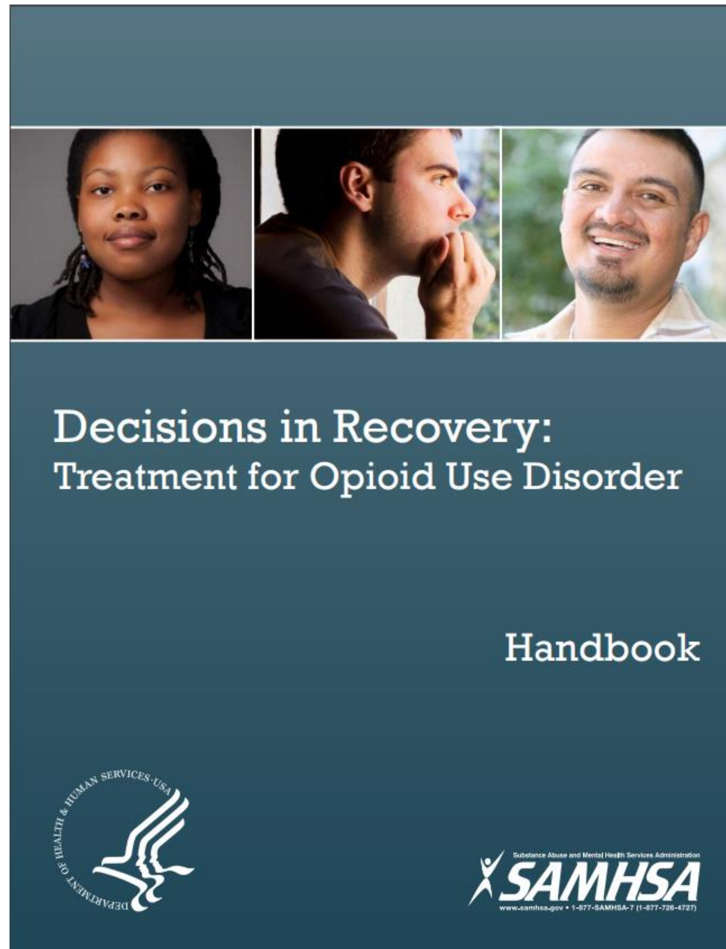
1. Choice Talk → help patient to understand that choices exist and that they are invited to participate in making decisions related to their treatment.

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.

Glyn Elwyn, Dominick Frosch, Richard Thomson, Natalie Joseph-Williams, Amy Lloyd, Paul Kinnersley, Emma Cording, Dave Tomson, Carole Dodd, Stephen Rollnick, Adrian Edwards, Michael Barry. Shared decision making: a model for clinical practice (in press: Journal of General Internal Medicine, 2012).

Shared Decision-making



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

DYSFUNCTION
THE ONLY CONSISTENT FEATURE OF ALL OF YOUR DISSATISFYING RELATIONSHIPS IS YOU.
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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.

Getting Started

- 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?"*

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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

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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.”

DILBERT

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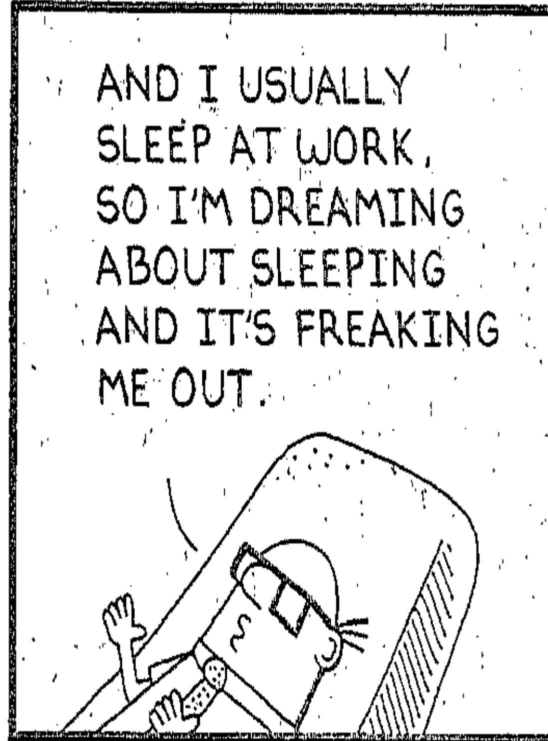

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Organizational Toolkit on Medication Adherence

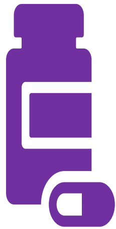
Practitioner Focus

- 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

Questions

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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/

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http://pcss.invisionzone.com/register

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Addiction Technology Transfer Center	American Society of Addiction Medicine
American Academy of Family Physicians	American Society for Pain Management Nursing
American Academy of Pain Medicine	Association for Multidisciplinary Education and Research in Substance use and Addiction
American Academy of Pediatrics	Council on Social Work Education
American Pharmacists Association	International Nurses Society on Addictions
American College of Emergency Physicians	National Association for Community Health Centers
American Dental Association	National Association of Social Workers
American Medical Association	National Council for Behavioral Health
American Osteopathic Academy of Addiction Medicine	The National Judicial College
American Psychiatric Association	Physician Assistant Education Association
American Psychiatric Nurses Association	Society for Academic Emergency Medicine

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