Medication Adherence: Importance, Issues and Policy: A Policy Statement from the American Heart Association

Executive Summary

Medications do not work in patients who do not take them. However, medication nonadherence has been documented to occur in over 60% of patients with cardiovascular disease (CVD), associated with poor control of risk factors and eventual progression of the disease. Additionally, medication nonadherence in chronic diseases results in up to $300 billion of avoidable healthcare costs in US annually accounting for 10% of total U.S. healthcare costs. The health and economic consequences of medication nonadherence can no longer be ignored and necessitates targeted effort from policymakers and other stakeholders. As such, the American Heart Association (AHA)/American Stroke Association (ASA) has a goal of improving medication adherence in CVD and stroke prevention and treatment.

In the context of healthcare, adherence is commonly described as the "active, voluntary and collaborative involvement of the patient in a mutually acceptable course of behavior to produce a therapeutic result." Each patient may have a complex set of health beliefs, socio-economic difficulties, and other life circumstances that may influence their likelihood of adhering to their treatments as directed. In parallel, providers are as complex as the patients they care for. This paper explores medication adherence and all of its inherent issues in the context of four overlapping categories: patient-level, provider-health system level, cost, and system barriers. This paper also suggests several policy and structural changes that must happen at each level to reduce barriers to adherence and improve patient's overall health in the spirit of achieving AHA's goal to save lives from heart disease and stroke.

Table 1: Policy Recommendations to Reduce Barriers to Medication Adherence

Barrier	Recommendation
Patient-Level Barriers	Medication Therapy Management (MTM) programs should be standardized and promoted by CMS.
	Insurers, payers and PBMs should support the use of special dosage and delivery products and innovative packaging methods (e.g., blister packs) to facilitate patients' understanding of and adherence to their drug regimen.
	Effort should be made to explore ways to increase time for patient/provider communication and trust development.
	Policies that facilitate efficient, bidirectional and proactive data sharing between the various points of care should be identified and implemented.
	Improved adherence should be promoted as an outcome metric in payment models.
	Health plans, providers, and other stakeholders across the care spectrum should have increased latitude to develop and test adherence programs that are cost-effective and tailored to the needs of the populations they serve.
	A new safe harbor under the AKS that both explicitly protects adherence programs and incorporates safeguards to prevent fraudulent practices should be implemented.
Cost Barriers	Value-based Insurance Design models that support lowering or eliminating out of pocket costs for consumers for medications that are demonstrated to be "high-value" should be encouraged.
	FDA should implement mechanisms that encourage the development and use of generics when appropriate and result in lower costs for patients.
	Further examination of the pharmaceutical distribution chain is required to improve patients' understanding of where costs are being added to the overall cost of their medications.
	Actionable information regarding out of pocket costs for different medications should be readily available to patients at the point of sale. Gag clauses between pharmacies and pharmacy benefit managers should be prohibited.
System Barriers	States should be encouraged to allow prescriptions to expire 15 months after the date of the original prescription so that any time lag in a patient's scheduling of a follow-up visit does not risk impacting adherence to medication in the interim.
	Medication synchronization that aligns patient refills to occur on the same day so that the patient only needs to visit the pharmacy once per refill period, should be used to encourage adherence. Patients who intentionally stagger their refill schedules due to financial limitations, should be allowed to opt-out of these programs.
EHR Barriers	Wasteful or duplicative EHR metrics should be removed.
	Efficient electronic means of communicating the discontinuation of a drug from the EHR to the pharmacy and between providers should be implemented. Current medications should be verified and discontinued medications should be clearly deleted from patients' medication list.