May 7, 2012

Vice Admiral Regina M. Benjamin, M.D., M.B.A.
Department of Health and Human Services
Office of the Surgeon General, Room 710-H
200 Independence Ave. SW
Washington, DC 20201

By electronic submission: medadhere@hhs.gov

RE: Request for Information on Prescription Medication Adherence, *Federal Register*, April 5, 2012 (p. 20637)

Dear Dr. Benjamin:

AARP appreciates the opportunity to submit comments on prescription medication adherence. As prescription drug use typically increases with age, our members are potentially most at risk of consequences from poor adherence. Of persons age 60 and older who were asked about their prescription drug use during 2007-2008, over one-fourth (27.3%) reported using three-to-four drugs, while more than one-third (36.7%) said they used at least five prescription drugs per month.[i] Medicare Part D enrollees filled an average of 37 prescriptions in 2010, or approximately three per month.[ii]

Causes: Adherence challenges stem from multiple causes, including: forgetfulness, regimen complexity, fear of or unfamiliarity with side effects, and economic concerns. Regardless of age, reasons for being non-adherent may change with the prescription, prescriber, condition; one's daily schedule, support network, and/or personal finances.

Impact: Three-fourths of all physician office visits end with a prescription being written. However, about 10%-20% of people do not fill a new prescription, and about half of people do not use medication as prescribed.[iii] Prescription drug-related morbidity, including poor adherence, may cost society up to $290 billion annually (NEHI).[iv] Older adults who see multiple prescribers, and who use multiple pharmacies, may be most at risk of drug-related problems.

Solutions: If there is one point of agreement among medication adherence researchers, it is that there is no "silver bullet" solution. Thus, patient-clinician adherence conversations should begin at the point of prescribing, and be reinforced throughout the medication use system. To do this, several positive, multi-faceted developments in adherence should be accelerated:

1. Build-out Medicare Part D quality measures that address adherence, several of which exist at the pharmacy level. These represent snapshots of patient adherence at a point in time, for medications that treat chronic conditions. Measures should reflect the entire medication use spectrum, with timely feedback of adherence problems – and their resolution – to prescribers and other clinicians.
2. Align quality measures for accountable care organizations (ACOs), many of which address medication management, directly with Part D quality measures. Part D medication therapy management (MTM) services could help to bridge these two programs, but only if all clinicians involved are held accountable for patient outcomes where drug therapy is part of the treatment regimen.[v]
3. Expand collaborative practice agreements to enable prescribers, pharmacists and nurses to more efficiently foster team-based adherence solutions. This will require more robust clinical data exchange between team members. Integrating clinical pharmacists into patient-centered medical homes could facilitate patient-clinician discussion about treatment goals, options, and patient preferences; and help to generate buy-in of prescribed drug (or non-drug) therapy.[vi] Clinical pharmacists could routinely (1) meet with patients who acknowledged having, or who may be at risk of having, adherence problems; (2) share data and present recommendations to prescribers; and (3) assist patients to implement solutions.

In conclusion, medication adherence challenges must be addressed throughout the medication use continuum. Prescribers, pharmacists, and other clinicians must assess and reinforce with patients the value of therapy when the prescription is written, at the pharmacy, at home, and during transitions of care. Incentives for helping patients achieve desired clinical and daily-living outcomes must be aligned for team members. If you have any questions regarding these comments, please do not hesitate to contact KJ Hertz on our Government Affairs staff at (202) 434-3732 or khertz@aarp.org.

Sincerely,

David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs

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[i] Gu Q, Dillon C, Burt V, "Prescription Drug Use Continues to Increase: U.S. Prescription Drug Data for 2007-2008," *Data Brief*, National Center for Health Statistics, CDC, No. 42, Sept. 2010, http://www.cdc.gov/nchs/data/databriefs/db42.htm

[ii] Tudor C, Medicare Prescription Drug Benefit Symposium, CMS, March 2012, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html

[iii] *2011 Drug Trend Report*, Express Scripts, April 2012, http://www.express-scripts.com/research/
[iv] *Thinking Outside the Pillbox*, NEHI, Aug. 2009, http://www.nehi.net/publications/44/thinking_outside_the_pillbox_a_systemwide_approach_to_improving_patient_medication_adherence_for_chronic_disease
[v] CMS, Announcement of Calendar Year 2013 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, April 2, 2012, pps. 119-120. https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2013.pdf
[vi] Berdine H, Dougherty T, et al., "The Pharmacists' Role in the Patient-Centered Medical Home," *The Annals of Pharmacotherapy*, April 24, 2012, http://www.theannals.com