Opportunities and challenges in providing face-to-face and telephonic MTM services to a commercially-insured population

Crawford SY,[1] Touchette DR,[1] Sharp LK,[1] Shaw JW,[1] Provenzano A,[2] Papa A,[3] Harkins T.[4]

[1]University of Illinois at Chicago Department of Pharmacy Systems, Outcomes and Policy;
[2]New Albertson's, Inc.; [3]Humana, Inc.; [4]Comprehensive Health Insights

WHAT WE LEARNED

- Commercially-insured patients with **higher out-of-pocket prescription costs** were more likely to consent to MTM services, as were **older patients**.
- Patients from neighborhoods with lower incomes more likely to consent to MTM, as well as patients from zip codes with higher African American population.
- More challenging to reach commercially-insured population for MTM recruitment and scheduling compared to Medicare population with drug coverage.
- If MTM services limited to weekdays, more limited pool of patients that could benefit as the service may not be offered at times they can accommodate.
- Double work for pharmacists to enter data for various MTM programs (study related and other) in different formats and/or forms and time-consuming to navigate software programs from different vendors. Need technologies that allow for integration in main, corporate pharmacy system.
- Beneficial MTM services by pharmacists may not be readily apparent as they also involve actions *not* showing up in claims data, e.g., switching times for drug therapy, monitoring use of nonprescription drugs and dietary supplements, or recommending disease prevention and health promotion activities.
- After initial puzzlement and upon engagement with pharmacists, patients grateful for the MTM services provision. Efforts should emphasize to patients when the health plan is working with pharmacists and how efforts are designed to help the patient
- Strong commitment demonstrated by pharmacists participating in study, both to their patients and to the success of the research project.

Background

- Medication therapy management (MTM) programs are designed to improve patient outcomes and decrease costs.
- Pilot study was conducted on MTM interventions for a commercially-insured population of patients with **dyslipidemia and/or diabetes**, with prescriptions dispensed at Jewel-Osco pharmacies, a large regional chain in greater Chicago.
- Targeted enrollment was inclusive and *not* limited to patients with high prescription drug costs, multiple chronic conditions, or multiple medications – in consideration of sample size and varying MTM needs.

Objective

To describe pharmacist-reported opportunities and challenges and compare characteristics of commercially-insured patients who agreed or declined to participate in face-to-face or telephonic MTM services provision.

Methods

- Patient claims data provided by **Comprehensive Health Insights**.
- **Eligibility:** Humana plan enrollment, prescription fill(s) by Jewel-Osco, and ages 18 to 89 *excluding* Medicare prescription drug coverage.
- Assigned patients contacted by telephone, maximum of 3 attempts, and invited to receive comprehensive MTM services free of charge either face-to-face by **Jewel-Osco pharmacists** or telephonically by **Humana RxMentor pharmacists**. Group allocations made based on historical yields to telephone scheduling attempts.
- Census data, geocoded by zip code, merged with claims data.
- Procedures approved by the local IRB and Humana ethics committee.
- Mixed qualitative and quantitative(α=0.05) methods; data collection year 2012.
- Telephone interviews on opportunities and challenges conducted in a semi-structured format with pharmacists providing MTM services for enrolled sample. Thematic definitions, coding, and agreement performed by two investigators.

Results

QUALITATIVE FINDINGS

- 15/27 (55.5%) pharmacists providing MTM services for participants interviewed. Thematic analysis summarized as pictured in Word Cloud, text, and graphic.

"In commercial population, many patients not on a lot of meds. If on a lot, they can understand why it would be good for pharmacists to talk to a patient. But for the patients not on many meds, …'Why do I need this?' … I try to find something that maybe they didn't know before and talk about that as well as meds – lifestyle, diet and exercise."

"… Very surprising for patients why they are [here at pharmacy]. But, once they go through it … very satisfied."

"The hardest part is scheduling time (for MTM) when patients want."

"Only difference (telephonically) with no-show from in-person visit is they (patients) just don't answer phone or are unavailable."

"Usually MTM patients have 9 or 10 meds, but these may have 2 or 3. [It] does not take the full hour for consult. [But] lot of people say thank you so much. Can't believe you guys are doing that."

"Navigating around that website (data entry site) was a little challenging … but got used to it. Every website you go into, it would be ideal if they were all the same in a perfect world in 20 to 30 years…"

"The commercial population is a different beast."

"We had some kinks to work out in logistics (initial scheduling). Once got that all taken care of, going really well."

"Study was set up well … A complaint that a lot of people have is the paperwork for the … study and their own paperwork."

"(Patients) know a lot about meds already. The issue is non-compliance. They don't know why they need 3 medications for blood pressure. I explain, do a lot of education … about how the 3 meds work in different mechanisms."

"…documentation for (study) challenging. Right now, system integrated in [vendor platform]… with (this) study, have to go on to the website to submit claim… Had to come up with different way to follow up with these patients, harder to document. Takes longer to follow up."

"I think this is a very beneficial activity for us to participate in. One-on-one time is very beneficial for us and patients … relationship building."

"I did not know my insurance would do this for me!" / "Is my insurance going to find out about [this]?"

"Almost 100% of the time, I get a very heartfelt thank-you … I hear that repeatedly over and over, even if they were only on a handful of meds."

Sometimes when pharmacist recommended less expensive medications, patient (said), "No, no, no … don't want to change meds" or "Don't discuss that with my doctor. He'll think I don't want to do what he wants me to do."

On the other hand: "Those (for whom) cost is an issue are more motivated to have [pharmacist) contact doctor."

"Pharmacists are committed to patient care. I really tried to figure out how to make it work (drew the line at coming in on Saturday). I really want this to be as successful as possible."

"Going over medications and making recommendations for the patient always goes well. Communicating with doctors and having recommendations accepted always goes well. Getting buy-in/support from doctor … patient okay with that if doctor okay with that."

QUANTITATIVE FINDINGS

- Out of 3207 eligible patients, 1456 (45.4%) could not be reached via telephone, 1497 (46.7%) declined MTM participation, and 254 (7.9%) consented.
- Schedulers for face-to-face arm reached a higher proportion (67.2%) of allocated sample by phone than the telephonic arm, which reached 35.5%; χ^{2}=310.5, df=1, p<0.001. Conversely, a higher proportion of consents was achieved via calls by the telephonic MTM group (consenting 29.1%) in comparison with calls for the face-to-face group (consenting 9.4% of attempts), χ^2 = 105.5, df 1, p<0.001.
- Differences found in groups reachable via phone (Table 1). Mann-Whitney U tests (skewed data) showed higher mean emergency room visits and total prescription costs for patients reached by phone than the unreachable group. No differences (p>0.05) shown in other utilization, gender, or adherence as measured by proportion of days covered (PDC) for oral antidiabetic medications or statins.

Table 1. *Mean differences unless indicated otherwise.*	Reached by phone	Unreachable	*t*	df	*p*-value
Age	58.69	56.82	-4.969	3205	<0.001
Neighborhood characteristics					
Median household income	$63,691.52	$61,196.90	-2.929	3187	0.003
Percent civilian population with health insurance	86.280	85.585	-3.070	3187	0.002
Percent white, non-Hispanic	47.016	43.042	-3.488	3187	<0.001
Percent high school or higher	87.083	86.281	-2.755	3187	0.006
Percent baccalaureate or higher	32.130	30.452	-2.791	3187	0.005
Percent foreign born, not U.S. citizen	47.602	48.566	2.205	3185	0.043

- *Among reachable patients,* differences (p<0.01) between consenters and decliners, respectively, of MTM services participation based on *t*-tests of mean age (61.06 vs 58.29) and NDC counts (6.43 vs 5.71), and Mann-Whitney tests of mean prescription out-of-pocket costs ($302.87 vs $255.76) and total prescription costs ($1,163.72 and $2,334.25). No differences revealed in medical out-of-pocket costs, total medical costs, PDC, or comorbidity index.
- Consenters were from neighborhoods with lower household incomes than decliners (respective medians $60,060 vs $64,306 and means $74,256 vs $80,554), p<0.05.
- Differences (p<0.05) found in neighborhoods with high percentage of white race (consenting 49.17% vs 56.98% declining) and neighborhoods with high percentage of black race (consenting 38.59% vs declining 30.14%).

Conclusions

- The 8% of eligible commercially-insured who consented to MTM services is lower than the typical 13% for Part D MTM programs.
- The commercially-insured population is younger and more mobile than most Medicare prescription plan beneficiaries. Other population differences included: working and harder to reach, not on as many medications, and more involved in their own care decisions.
- Opportunities exist to tailor innovative MTM programs to patients ~60 to 64 years old with complex or expensive medication regimens (i.e., higher out-of-pocket costs), and those in neighborhoods with lower income and/or higher minority population.

Acknowledgements

We are grateful to the Pharmacy Quality Alliance, Inc. (PQA) and Humana RxMentor (in-kind support) for project sponsorship. Data for MTM interventions were collected and managed using Research Electronic Data Capture (REDCap) tools via grant support of the UIC Institute for Health Research and Policy grant UL1RR029879.

GCHJBV6EN