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

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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 time-consuming to integrate 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 up engagement with pharmacists, patients grateful for the MTM services provision. Efforts should encourage to patients when needed.
- 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.

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.

Method

- Patient claims data provided by Comprehensive Health Insights.
- Eligibility: Humana plan enrollment, prescription fill(s) by Jewel-Osco, and ages 18 to 83 excluded.
- 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 Human ethics committees.
- Mixed qualitative and quantitative(<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

- 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%; χ²=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). χ² = 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.

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 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

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Methods

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Table 1: Comparison of differences between those contacted and those unreachable

<table>
<thead>
<tr>
<th>Age</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>65-69</td>
<td>0.003</td>
</tr>
<tr>
<td>70-74</td>
<td>0.002</td>
</tr>
<tr>
<td>75-79</td>
<td>0.001</td>
</tr>
<tr>
<td>80-83</td>
<td>0.005</td>
</tr>
</tbody>
</table>

Neighborhood characteristics

<table>
<thead>
<tr>
<th>Median household income</th>
<th>68,693.52</th>
<th>101,196.38</th>
<th>&lt;0.001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent non-whites, non-Hispanic</td>
<td>31.85</td>
<td>30.75</td>
<td>0.006</td>
</tr>
<tr>
<td>Percent high school or higher</td>
<td>63.95</td>
<td>62.28</td>
<td>0.007</td>
</tr>
<tr>
<td>Percent bachelor’s or higher</td>
<td>33.10</td>
<td>29.45</td>
<td>0.001</td>
</tr>
<tr>
<td>Percent under 10-year-old</td>
<td>30.63</td>
<td>28.21</td>
<td>0.007</td>
</tr>
</tbody>
</table>

Among reachable patients, differences (p<0.05) between consensus 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 ($502.87 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.

- Consenting were from neighborhoods with lower household incomes than decliners (respectively median dollars $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%).