Transcript Details
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Pathways Toward Better Lipid Medication Adherence

Narrator:

Welcome to ReachMD. You are listening to **Lipid Luminations**, produced in partnership with the National Lipid Association and supported by an educational grant from AstraZeneca. Your host is Dr. Alan Brown, Director of the Division of Cardiology at Advocate Lutheran General Hospital and Director of Midwest Heart Disease Prevention Center at Midwest Heart Specialists at Advocate Health Care.

Dr. Brown:

Welcome to Lipid Luminations. I'm your host, Dr. Alan Brown, and we're broadcasting live from the National Lipid Association Meeting at the Palmer House in Chicago, Illinois. My guest today is Dr. Lynne Braun, who is a PhD, a certified nurse practitioner, a Fellow of the Heart Association, and a very powerful person within the National Lipid Association, a mover and shaker here. She's a professor at the Rush College of Nursing and Nurse Practitioner in the Rush Heart Center for Women in Chicago and a wonderful resource to the Lipid Association.

Lynne, I know one of your passions is dealing with the Achilles heel of all therapy, which is even if it works, if a patient doesn't take it, it does no good, right?

Dr. Braun:

Exactly.

Dr. Brown:

So, my father used to say, “The worst medicines are the ones that people don’t take or don’t work.”

Dr. Braun:

Don't take, right.

Dr. Brown:

So, let's talk a little bit about medication adherence. This topic is a little dear to me because I remember in our own practice trying to figure out why we couldn't achieve adequate targets. And there was a wonderful paper that Tom Pearson wrote several years ago that was many, many pages with all the psychological barriers and all these other barriers, and I was impressed by all of that. But, actually, once we put an alert on your computer that just reminded us when the patient was in front of us to treat, a big portion of the achievement of goal improved. But it seems like with systems being an important part of getting people treated, there is still that magic number you

can't get beyond. About 30% of people just don't get to their targets, and I'm convinced that that's for all those other reasons that Tom wrote about and that you're going to talk about today.

So, tell us, what do you think are the major issues of adherence? Whose fault is it? Let's start with that.

Dr. Braun:

I think it's the system's fault. It's the provider's fault in large part, actually. And, certainly, the patient has their own idiosyncrasies; they have their own concerns. But as providers, we can certainly address those concerns that our patient has by, first of all, establishing a great relationship with our patient, whether it's the relationship between the patient and the provider himself or the patient and the provider's staff and people and office, the entire team approach. I think in the recommendations Part 2, in addition to talking about adherence, we talk about the entire healthcare team, engaging them in patient care. Wouldn't it be great if you started a new medication on your patient and a week to 10 days later one of your staff called that patient to say, “Do you have any questions? Do you have any concerns about that medication? Did you fill that prescription?”

Dr. Brown:

“Are you taking the pill?”

Dr. Braun:

“Are you taking the pill?” If we did follow-up like that, I think it would be amazing. But, if that can't happen, if the provider just had enough time to really fully explain the rationale for the medication to the patient, to sit down and listen to their concerns and questions, to make that patient feel part of the team, you know, because the patient really is the most important part of the team, it's not just the providers.

Dr. Brown:

Right, and people have said the most important part of patient care is caring for the patient.

Dr. Braun:

Yeah, exactly.

Dr. Brown:

And the patients, if they know that their best interest is at heart, that they will tend to follow your instructions because they trust you, and that doesn't take a huge amount of effort. I'd like to think many practitioners practice that.

Dr. Braun:

The other thing I get real concerned about, and I've developed a keen interest over the last few years, is the issue of health literacy. Just because you may be caring for a lawyer who makes a million dollars and who's gone through years and years of education doesn't mean they're health literate. I have a particular lawyer who I take care of who, he's brilliant, but he's not health literate. Many of my less educated patients are more health literate than he is. I remember caring for an orthopedic surgeon who knew nothing about his secondary prevention medications. So, we can't assume just because someone has a particular educational level that they're going to be health literate and really understand the information we're delivering.

Dr. Brown:

I think that's a really critical point, and if you don't ask, sometimes patients will try to impress you with what they know about medicine

and you get the impression they understand this, the so-called read back technique where you say to them...

Dr. Braun:

Teach back, yeah.

Dr. Brown:

“Tell me what...”

Dr. Braun:

Or read back, yeah.

Dr. Brown:

"Tell me what you learned today at today’s visit.” The other thing that I'd love to hear your thoughts on are the idea of making sure that you just ask the right questions no matter what the answer is. So, when the patient comes in, if you just attend to it, as Dr. **McKinney*** would say, “Ask them how they are doing on their diet.” If we never mention the diet, the perception is it's not important.

Dr. Braun:

It's not important, that's right.

Dr. Brown:

“Are you taking your pills every day?”

Dr. Braun:

Yeah.

Dr. Brown:

If not, why not? I had one patient that told me he forgets every day and he had to take his pill at bedtime, so I asked, “What do you do every night before you go to bed?” He brushes his teeth. So I told him, “Rubber band the pill to the toothpaste,” right?

Dr. Braun:

Right.

Dr. Brown:

Something that I learned from talking to people like you that I otherwise might not have mentioned. He said, “Oh, I could do that.”

So, do you have any other pearls about how to interview patients and try to figure out the barriers that might be keeping them from taking their pills?

Dr. Braun:

One of the things I think in practice that we forget to do is to ask the adherence question. You know, we assume because we may see a particular LDL level that they're adherent. That's an important clue, but it may not be everything, and they may not be adherent. And just by asking a question, you know, I give kudos to the people who actually use the Morisky scale and do this more formally, but I just ask one question, and that is, "In the last 2 weeks, what percent of – you know, you should have had 14 doses of your statin. How many doses do you think that you took?" And if it's anything less than 12 or 14, I start to pursue it then. And really ask, "What's going on? Are you forgetting? Is it that you don't want to?" Really explore the reasons why patients are not 100% adherent. But we have to ask an adherence question. That's really key. I have a patient who, as I walk into the room, she says, "70%" before we start talking about anything, you know.

Dr. Brown:

That's cute.

Dr. Braun:

Yeah.

Dr. Brown:

So, this is making me think about many of my patients who come in and they tell me something, then when their spouse gets in the room, they say that's absolutely not true. So, what is the role of the family member, and do you think getting nagged by your spouse is a positive or a negative thing in terms of adherence?

Dr. Braun:

Nagging is not good. In fact, we had an NIH-funded study some years back called A Couples Approach to Cardiac Risk Reduction where not only did they get an education about everything we should be teaching our patients who've had a coronary disease event and their spouse, but we also, the psychologist involved, taught the couple how to best work together as a couple, so problem-solving techniques, emotional expressiveness, things like that, as opposed to nagging -- because I see that all the time as well. So, no, nagging is not the answer, but involving and engaging the family member and teaching when they're there so they both hear the same information from you, the provider, and can hopefully then work together, and maybe something comes up where they do work together better as a couple, whether it's grocery shopping together or whatever they can do to make healthcare for both of them better.

Dr. Brown:

It goes back to the golden rule of life, business, healthcare, and relationships.

Dr. Braun:

Yeah, exactly.

Dr. Brown:

Which is that the way you influence people. It has nothing to do with what they think about you, it's how they feel about themselves when they're in your presence.

Dr. Braun:

Right.

Dr. Brown:

And when I do see families that say, “We love you, we don't want anything bad to happen to you,” that's much more effective than, “I'm going to slap you if you don't take your pills,” right?

Dr. Braun:

Exactly.

Dr. Brown:

So, any other clues about adherence? I mean, tell us about some other barriers that we should be asking about besides just querying how many pills they're taking and trying to engage things that are important to them, like possibly family?

Dr. Braun:

So, the 3 things that I'm going to focus on in the talk that I'm going to give a little while ago, or a little while from now, is the patient/provider relationship or the relationship between the patient and the entire healthcare team, and the patient as being the most important part of the team. The second is health literacy. I think we have to try and identify cues from our patients to tell us that they have a low level of health literacy and then figure out some strategies to address that. And the third area that I really worry about, Dr. Brown, is care transitions, patients discharged from the hospital, they're coming home. And I'm sure so often you identify as well that patients may be discharged with a particular list of medications, and they come home, they could be taking 2 of the same medicines in the category because it wasn't on the formulary in the hospital, whatever you prescribed them, and now they're taking 2 different statins, for example, or for some reason the statin fell off and it's not on their list. The more we can followup on patients with that 2-day post discharge phone call and then a week to 10-day post discharge visit, and perhaps when there's a discrepancy, having myself -- I call the pharmacy a lot -- to review when the last time the patient refilled their medication.

I'm going to be presenting a case of a cardiac transplant patient who was hospitalized for another reason and had a very high LDL cholesterol. Patient was referred to me. It turned out that the patient last filled their statin medication prior to that hospitalization, which was now a few months ago. He thought he was taking the medication. The transplant cardiologist thought he was taking the medication. He wasn't taking the medication, and we didn't know that until I called the pharmacy.

Dr. Brown:

Yeah, so I mean, we're all looking for...

Dr. Braun:

So, that's a very vulnerable time. It really is. It really is. And one of the other pearls I think of this meeting today is motivational interviewing. I'm going to talk about that a little bit perhaps. Dr. Resnick follows me, and he's the expert in that area, but it's one way to really engage the patient without talking at them, you know, finding out what their perspectives are, what their values are, how they live their lives, what their concerns are in order to move the needle a little bit as far as making a behavior change like good medication adherence.

Dr. Brown:

For example, "I just had a new grandchild," right? So, they want to live to enjoy that grandchild.

Dr. Braun:

Absolutely.

Dr. Brown:

And if you have that information, is that what you mean?

Dr. Braun:

Exactly. Well, or really finding out why they're resistant and letting them talk, instead of us talking at them, letting them talk. And there are techniques to kind of trigger and pull that information from them. "You're concerned because of side effects," and let them talk about the side effects that they may have heard. You know, another pearl with lipid-lowering therapy is really to address side effects up front and let them though that there's a certain percentage, but if they feel like, feel as though they're having an adverse effect, they need to contact you. They shouldn't stop the medicine and tell you about it 3 months when they return. They need to contact you, they need to contact the office staff, because we can work through those things here and now and not 3 months from now.

Dr. Brown:

Well, thank you very much, Lynne. I could talk to you about this all day, very, very interesting. If I could summarize what I think you said, and you tell me if I'm right, that a systematic approach to managing patients is a critical first step; an individualized approach to assessing patients' adherence, and if they're not being adherent, to try to attend to it; ask questions about why they're not taking their medicine is the first step just to show the patient it's important; to have the right kind of communication with your patients, so it includes listening.

Dr. Braun:

Absolutely.

Dr. Brown:

And then the bigger issue of health literacy, which is going to require a lot of work, and finally, a universal medical record that combines inpatient and outpatient care so you have your one lifelong record and everybody can see what drugs you're supposed to be on throughout the continuum of care. There's been a lot of talk about it, but I'm not aware of anybody accomplishing that yet.

Dr. Braun:

No, I don't think so.

Dr. Brown:

Except maybe.