The Key To Better Medication Adherence Is Better Physician-Patient Communication

The Evidence Linking Better Health Outcomes And Lower Costs To Better Physician Communications With Patients

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**Introduction**

Effective physician communication skills are as essential to the delivery of high-quality medical care as is clinical knowledge\(^1\). The physician’s ability to talk with and listen to patients is the primary process by which medical decisions about diagnosis and treatment are made and patient engagement assured. The evidence shows that physicians with strong patients communications skills tend to have better outcomes, higher levels of patient trust, adherence and satisfaction and lower health care use and costs\(^2\).

This paper is the first in a Master Series that will explore the evidence linking physician-patient communications to many of today’s health care goals and priorities. In this paper, the author, Stephen Wilkins, MPH, Author of Mind the Gap Blog and Founder of the Adopt One! Challenge, investigates the “positive and significant correlation” between the quality of physicians’ patient communication skills and medical adherence.

In addition to reviewing the published evidence, the author looks at the patient communication best practices of “high performing” physicians to see what separates them from the rest when it comes to patient medication adherence.

Over the course of this series, we will look at how patient-centered communication skills and techniques - the gold standard for high quality patient communications – can transform any clinician into a “high performer” when it comes to:

- Patient engagement
- Adherence
- Patient trust
- Adoption and integration of health IT
- Patient health outcomes
- Cost and value
- Patient experience

Two patients each visit their physicians with identical complaints and receive identical prescriptions. But only one of the patients fills the prescription.

The aim of this paper is help understand why...and what can be done to improve medication adherence.
Medication Nonadherence – A Gigantic Public Health Problem

Medication nonadherence is a public health issue of “gigantic proportions” in terms of its impact on patient outcomes, health care utilization and cost. Approximately one half of all adults in the U.S. take at least one prescription medication. Medication prescribing is the most common “treatment” provided by physicians. Three quarters of all patient visits to physicians’ offices are by patients taking a prescription medication.

Up to 50% of all patients prescribed a medication are or will be nonadherent. The number of medications a person takes each day is inversely related to their expected adherence. For patients taking more than one prescription a day, which includes most seniors, medication nonadherence can be as high as 70%.

Definition of Medication Adherence

Medication adherence is broadly defined as taking a medication as prescribed, e.g., in the right amount, for the prescribed duration and in the recommended way. Adherence is the result of the active, voluntary collaboration between patient and physician to produce a therapeutic result.

Medication nonadherence is where patients do not take their medications as prescribed by their physician.

Medication nonadherence includes patients who:

- Never fill, pick-up, or take a newly prescribed medication – called primary nonadherence.

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Intentional nonadherence is often a rational response by the patient to a disagreement with the physician’s recommendation to take a medication.

*Mitchell, A. et al. Advances in Psychiatric Treatment. 2008*

Do not take their medication in the amount, time or method prescribed – called secondary nonadherence.

Medication nonadherence can also be broken into two types: *intentional and unintentional*. Intentional nonadherence is where the patient makes a conscious decision to not fill, pick up from the pharmacy, or take a medication as prescribed. Intentional nonadherence is often a rational response to:

- A disagreement with their physician’s diagnosis necessitating the medication.
- A disagreement with their physician’s assessment of the severity of the health problem necessitating the medication.
- Concerns about the safety of the medication prescribed.
- Concerns about the efficacy of the medication prescribed.
- Concerns about the cost of the medication.

A 2003 report by the Boston Consulting Group estimated that 75% of all medication nonadherence is intentional...and that only 25% was unintentional, e.g., the result of forgetfulness and so on.

Medication persistence is a related problem referring to how long patients take a medication before stopping. Between 25% and 50% of patients, including many with chronic conditions, discontinue prescribed medications within 60 days of starting it.

A 2003 report by the Boston Consulting Group estimated that 75% of all medication nonadherence is intentional...and that only 25% was unintentional, e.g., the result of forgetfulness and so on.
The Cost of Medication Nonadherence

Medication nonadherence is responsible for 10:

- 125,000 preventable deaths per year
- $290 billion in annual health care costs
- 27% of preventable ER visits
- 33% - 69% of all medical hospital admissions
- 11% of all hospital readmissions.

Medication nonadherence not only compromises patient health outcomes, but it also has significant cost implications. The cost of treating nonadherent chronic disease patients is at least twice as high as adherent patients with the same conditions 11.

Table 1 below presents the findings from a 2005 study of the medical costs associated with adherent and non-adherent hyperlipidemia and diabetes patients 12.

<table>
<thead>
<tr>
<th></th>
<th>Hyperlipidemia</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonAdherent</td>
<td>$6,810/pt.</td>
<td>$8,812/pt.</td>
</tr>
<tr>
<td><strong>Cost Difference</strong></td>
<td><strong>$3,686/pt.</strong></td>
<td><strong>$5,004/pt.</strong></td>
</tr>
</tbody>
</table>

These findings are consistent with those reported in a 2009 study of Medicaid Congestive Heart Failure Patients 13 in which adherent patients (with an 80%+ Medicine
Nonadherence is associated with increased asthma symptoms, frequent emergency department visits, hospitalizations, and need for oral steroids.

Given the number of patients seen for asthma each year, the medical visit is a prime opportunity to promote adherence.

Borrelli, B. et al. Journal of Allergy and Clinical Immunology. 2007.

Too many studies have been based on the assumption that patients should be passive, obedient and unquestioning recipients of medical instructions. The investigations therefore sought what was wrong with the patient to lead to noncompliance.


Possession Ratio) had total costs that were $5,910 less than their nonadherent counterparts (Medicine Possession Ratio <80%).

Table 2 shows the difference in inpatient and ER utilization by adherent versus nonadherent CHF patients from the Medicaid study 14.

### Table 2
**Medicaid Congestive Heart Failure Study**

<table>
<thead>
<tr>
<th></th>
<th>Adherent (n = 19,912)</th>
<th>Nonadherent (n = 17,496)</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Hospitalization</td>
<td>47.5</td>
<td>47.9</td>
<td>-0.4</td>
</tr>
<tr>
<td># Hospitalizations</td>
<td>1.4</td>
<td>1.6</td>
<td>-0.2</td>
</tr>
<tr>
<td># Hospital Days</td>
<td>5.9</td>
<td>8</td>
<td>-2.1</td>
</tr>
<tr>
<td>Any ED Visit</td>
<td>43.7</td>
<td>45.1</td>
<td>-1.4</td>
</tr>
<tr>
<td># ED visits</td>
<td>3.6</td>
<td>4</td>
<td>-0.4</td>
</tr>
</tbody>
</table>

Key Drivers of Medication Nonadherence

Historically, patient nonadherence has been viewed in the medical literature as a “lack of commitment” by the patient to their treatment plan 15. Until recently, the conventional view was that patients were nonadherent because they weren’t motivated enough, engaged enough or smart enough to do what their doctor recommended.

This view has changed markedly over the last 20 years as researchers have begun to realize that physician communication practices, not just patient behavior, was driving medication nonadherence. Today, over 200 “factors” have been associated in the literature with
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medication nonadherence, with many of these factor clustering around the following two, key drivers:

• **Patient Factors** - Patient beliefs about their provider, condition(s), medication(s), level of knowledge about their condition(s), previous health experiences, health literacy, trust, emotional state, ability to pay, and demographics.

• **Physician Factors** – Physicians attitudes and assumptions about patients as well as their patient communication style and skills, e.g., their ability to engage patients, elicit their illness perspectives, and involve the patient in decisions about their health care.

As physicians, we've become adept at going on autopilot within a few seconds. We go into automatic thinking about what diagnosis the patient has and stop listening.

As physicians, we've become adept at going on autopilot within a few seconds. We go into automatic thinking about what diagnosis the patient has and stop listening.

Terry Stein, MD, Kaiser Permanente, Co-Creator of the Four Habits Model

The contributing role of physician communications in patient medication adherence is underscored by a 1990 report in which the Office of Inspector General (DHHS) speculated that:

“Inadequate [physician] communication about medications accounts for up to 55% of medication nonadherence.”

Over the last 40 years some 106 different studies have reported positive correlations between physician communication and patient medication adherence. In a much publicized 2005 meta-analysis of these studies, Zolnierek and DiMatteo found that:
“Patients of physicians who communicate well are 19% more adherent than patients of physicians who do not communicate well...the odds of patient adherence are 2.16 times higher if a physician communicates effectively”  

This odds ratio for effective physician communications is comparable to the odds for other important predictors of medication adherence in the literature, e.g., social support (3.6 time higher), emotional support (1.83 time higher), depression (3.03 time higher), and perceptions of disease severity (2.5 times higher).

By “communicate well”, the authors were referring to physicians that employ a Patient-Centered Communication Style. By “do not communicate well” they were referring to physicians that employ a physician-directed, Biomedical Communication Style, the style used by the majority of practicing physicians today.

A Few Words About Physician Communications Styles

A large body of research exists showing that physicians are predisposed to engage in certain communication styles; styles that can be observed and measured. Imagine a continuum along which the different patient communication styles of physicians are arrayed. (Figure 1).
At one end of the continuum is the **Biomedical** or **Disease-Oriented Communication Style**. Also referred to as **Physician-Directed**, physicians employing this style focus on obtaining only the biomedical information they feel they need to arrive at a diagnosis and treatment. The voice of the patient is largely absent from this communication style. The physician assumes the role of “expert”, is in control of the visit, does most of the talking and makes all the decisions while the patient assumes a “passive sick role.”

An estimated 75% of practicing physicians today employ a **Physician-Directed (Biomedical) Communication Style** – the same style they learned years ago in medical school.

At the other end of the communication continuum is the **Psycho-Social** or **Patient-Centered Style**. Clinicians employing this communication style strike a balance between focusing on the patient’s medical condition...
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Physician communication or the lack of it is probably one of the most important factors for patient noncompliance. Edward C. Rosenow III MD. Division of Pulmonary and Critical Care Medicine, Mayo Clinic

(Biomedical) as well as the person behind the medical complaint (Psycho-Social). They actively seek the “patient’s voice”, e.g., their story and perspectives, share control of talk time during the visit, and engage in more information sharing. In short, the patient is an active partner of the clinician employing a Patient-Centered Communication Style.

Patients Also Have A Communication Style

The vast majority of us assume a “passive sick role” when we become patients. As patients, we have been socialized from childhood into a role in which we: 1) implicitly accept that the doctor is “in charge” and 2) accept that our role is to basically help the doctor identify what is wrong and then do what the doctor tells us.

While counterintuitive to the image in the industry press of patients all being “empowered”, the literature shows that that most patient are passive in that we do not ask many questions (if any) during office visits nor are we likely to challenge our doctor’s opinions or recommendations out of fear of being labeled difficult.

It Is Not Just A Matter Of Communication Style

Analysis of exam room doctor-patient conversations reveals that many physicians provide spend little time explaining to patients the “ins and outs” when prescribing new medications. In one study, one quarter of patients did not receive any instruction from the doctor regarding how...
Patients were much less likely to take medication if beliefs and concerns [they held], that conflicted with their physicians’ beliefs, were not addressed. Bezreh, T., et al. Patient Preference and Adherence. 2012.

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to take their antibiotics. In that same study, physicians did not discuss the potential side effects of a new medication with patients in 66% of visits.

Perhaps the most surprising finding from the analysis of exam room conversations is that the average primary care physician spends less than 60 seconds out of a typical visit talking to patients about new medications:

- why a new medication is necessary
- how to take it along with dosages
- when to stop taking it and side effects

Figure 2 presents “talk time” (in seconds) for the topics discussed by primary care physicians with patients during office visits in which a new medication was prescribed.

Figure 2
On average, <11 seconds per visit was spent by physicians in the study explaining to patients the “Directions for taking medications.”

**How Patients Think About Medication Adherence**

As patients, we bring to our doctors not just a set of symptoms, we bring the health-related fears, beliefs, knowledge and experiences we have accumulated over the years. This includes a set of general beliefs about taking medications – beliefs that tend to remain stable over time and health history. These fears, beliefs, knowledge and experiences are the filters through which we see, think about and evaluate our health and health care options.

Absent new or additional knowledge, generally obtained from our physician, our perceptions are what guide our health-related decision-making.

According to research done by Horne et al., we as patients engage in a kind of cost/benefit analysis when faced with decisions such as taking a new medication or undergoing a specific medical treatment (See Figure 3).

**Figure 3**

*The Necessity/Concerns Framework*

- **High Necessity**
  - Accepting
  - Ambivalent
- **Low Necessity**
  - Indifferent
  - Skeptical

**In a 2011 study of low income patient being seen at Cardiology Clinic diagnosed with heart failure;**

- 55% of patients diagnosed with heart failure disagreed with their doctor’s diagnosis.
- 87% of patients diagnosed with hypertension disagreed with their doctor’s diagnosis.
- 41% of patients disagree with doctor’s initial diagnosis of a psychological problem


Patients frequently disagree with physicians’ diagnoses and treatment plans, leading to unfilled prescriptions, partially used medications, lack of follow-up with referrals and return visits, and poor clinical outcomes.

*Heisler, M. Circulation. 2008*
Instead of “costs”, we substitute our understanding of the “necessity” for going along with the doctor’s recommendation. Do we really need to do what the doctor is telling us?

We then balance our perceptions of the necessity for action against our “concerns”, (in place the benefits) about following the doctor’s recommendation. Is the medication or procedure safe? Do we think the medication will work, and if so, how well? How will taking the medication affect me in other areas of my life? Can we afford the medication? Does the doctor have our best interest in mind or does he/she have some financial interest in their recommendation?

As patients we seldom share our “necessity/concerns calculus” with their physicians. Our level of trust in our physicians has a lot to do with determining how much information we share. We do give clues to our thinking which the doctor may or may not be mindful of. We also don’t ask many questions when prescribed a new medication - in one study 47% of patients asked no questions at all when prescribed a new medication.

Depending upon the results of our “necessity/concerns analysis”, we then decide whether or not to take the medication or have the procedure.

Figure 4 presents a real world example of the rationale that goes into patients’ “necessity/concerns calculus”. The results are from a 2013 study of 98 Kaiser Permanente
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Patients keeping silent about their doubts could be demonstrating deference to doctors, or, alternatively, patients may fear provoking anger in the provider by admitting nonadherence. Questioning the provider risks creating tension.


members (>24 years old) who did not fill/pick-up an initial prescription for statins. The intentional nonadherence rate reported in the study was 20%.

An Applied Example - The Mediating Role Of The Physician’s Communication Style

Imagine an exam room in which a recently diagnosed, middle-aged, male diabetes patient has just been told by their doctor that they need to take insulin injections the rest of their life.

Immediately upon receiving the news from the doctor the patient’s mind starts racing. Should he accept the
doctor’s recommendation to go on insulin or not? Like many such situations, the patient initially develops a strong predisposition against taking insulin.

The patient’s resistance to taking insulin is driven by a combination of:

- Their beliefs about diabetes and insulin
- Negative self-perceptions and attitudinal barriers (sense of personal failure or self-blame for the necessity of insulin use)
- Fear of side effects and complications from insulin use
- Depression
- Concerns about lifestyle restrictions because of insulin use for the rest of their life
- Social stigma of having to take insulin

Absent an “information therapy intervention” by the physician aimed at helping this patient better understand the seriousness of their condition and the need to go on insulin, the patient’s “concerns” will trump their perceived “necessity” for the insulin. The net result is that this patient will be non-adherent.

So what would the exam room conversations between the patient and a primary care physician look like for a physician with a Biomedical or Physician-Directed style of communication look like? How would it compare to a physician with a patient-centered style?

Let’s find out.
Example #1 — A Physician-Directed Communication Approach

**Physician:** We have got to get your blood glucose under control. The Metformin is not enough. I will need to put you on insulin.

**Patient:** You mean shots every day?

**Doctor:** Yup…it’s the only way to get this problem under control.

**Patient:** My aunt had a touch of sugar and didn’t need insulin.

**Doctor:** Yeah well she’s not you

**Patient:** When would I need to start?

**Doctor:** Tomorrow if possible…the sooner the better

**Patient:** I hate shots…I can’t give myself shots every day.

**Doctor:** My nurse will show you how to do and you will get used to it.

**Patient:** Are you sure I need this?

**Doctor:** Let me give you a brochure which explains how insulin works and why your body needs it.

**Patient:** Ummhmmm

**Doctor:** I will send an e-prescription to the pharmacy and you can pick up your insulin on the way home. Let the pharmacists know if you have any questions.

**Doctor:** Now let’s talk about your weight….

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**Note how the physician in Example # 1:**

- Does not explain **why** the patient needs to go on insulin
- Ignores the patient’s expressed concerns about “shots” every day.
- Does not follow-up on patient’s beliefs/ experiences regarding his aunt’s diabetes.
- Misses several opportunities to provide empathy and support to patient.
- Misses opportunities to provide additional information regarding the severity of his condition and the necessity for insulin.
- Assumes patient will be adherent & makes no attempt to validate that assumption.
Given the importance to patients of balancing the “necessity” and “concerns” for taking a new medication, one would think that addressing these two issues would be a priority for physicians. A 2011 study however found that physicians addressed the seriousness of the patient’s problem [necessity] in just 30.2% of visits and the effectiveness of the prescribed medication [concerns] in 44.6% of visits\textsuperscript{30}.

Fast Forward 12 Months

Not surprisingly, the patient in the first example did not immediately agree with the physician’s recommendation to begin taking insulin. The patient filled the prescription and told the doctor they were trying it out. After a few months the patient, when confronted by the doctor, admitted to not taking the insulin.

Within 6 months, the nonadherent patient ended up in the ER twice with complications from their uncontrolled diabetes. This patient was hospitalized and placed on insulin after the second ER visit. The total cost associated with these events came out to over $60,000.

Example #2 – A Patient-Centered Communication Approach

Now let’s look at the exam room conversation between the same patient and a primary care physician employing a Patient-Centered Style of communication.
Note how the physician in Example # 2:

- Explains why the patient needs to go on insulin.
- Pick up on the patient’s fear about shots.
- Acknowledges how the patient is feeling – empathy.
- Asks about the patient’s perspective.
- Offers support and training to help patient but self-confidence and self-efficacy.
- Seeks patient agreement with care plan.

**Physician:** We have got to get your blood glucose under control. The Metformin is not enough. I am going to recommend that we get you started on insulin. It is absolutely the right thing to do for someone in your situation. Even with the Metformin, your system is not processing your blood sugar properly. Your A1C is not under control and other parts of your body will soon be affected.

**Patient:** You mean shots every day?

**Doctor:** Yes…I know how overwhelming this must be for you right now. Care to share your thoughts?

**Patient:** You got that right…I am kind of numb. I feel like running out of here screaming. I can afford the medication…after all I have insurance. I am just plain scared.

**Doctor:** I’d probably be feeling the same way if I were in your shoes. I am sorry you have to deal with all this. Good thing about the insurance.

**Patient:** Uhhmmmm

**Doctor:** It might help you if you better understood why you need insulin…what’s going on with your body and how insulin will help…[conversation about how insulin helps the body process glucose]…Before we do anything I want you to fully understand the decision before you. I am sure your mind is racing with questions.
Patients’ perceptions and beliefs should be fully understood in efforts to foster their adherence, and in the context of social and cultural sensitivity, physicians should assure that their patients fully understand the severity of their disease conditions and the necessity of carefully adhering to treatment.

*DiMatteo, R. et al. Medical Care, 2007.*

In a 2011 study of hospitalized patient, only 16% of physicians in the study (residents and attending physicians) admitted to routinely asking their patients about their health care-related expectations.

*Rozenblum, R. et al BMJ Quality & Safety, 2011*

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**Patient:** I am not sure where to start?

**Doctor:** Let’s start at the beginning with you understanding your options. Before you leave today let me hook you up with our diabetes care manager who can walk you step-by-step through the process of how to take insulin. Does that work for you?

**Patient:** I don’t want to talk the Diabetes person today. I need some time to think about this.

**Doctor:** I understand. This is a lot to get hit with all at once. Your reaction however is quite normal...there’s even a name for it – psychological insulin resistance. You can Google it to learn more.

**Patient:** I will believe me.

**Doctor:** Good. Let’s follow up in a week or so after you have had a chance to talk with our diabetic case manager. At that point we can decide how best to proceed.

**Patient:** Ok

---

**Fast Forward 12 Months**

The patient in the second example decided to go on insulin and was adherent. The patient met with the practice’s diabetes coordinator, learned how to administer the insulin and became very effective and confident in their self-care abilities. The patient was routinely followed up with by their primary care physician and their health care team of diabetic educators. The patient did not experience
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The physician’s understanding of the patient’s perspective helps to foster ‘productive interactions’ and enhance patient participation.

In this context knowing the patients’ worries about complications (rather than assuming) and preferences is vital in order to tailor information and treatment to the individual needs.


any ER visits or hospitalizations associated with their condition.

Five Patient Communication Best Practices Used By “High Performing” Physicians Linked To Increased Patient Adherence

#1 - It Begins With A Trusting Doctor-Patient Relationship

Physicians that consistently score high on measures of patient, trust, patient satisfaction and medication adherence, e.g., high performing physicians, understand the importance of investing some time in establishing and building strong, trusting relationships with patients.

They do this in part by inviting patients to participate in the visit by sharing their full story without interruption, participating in setting the visit agenda and sharing in decision-making. They understand the value of active listening and mindfulness during each visit.

High performing physicians see investing in the relationship as the right thing to do, and when it comes to adherence, a smart thing to do.

#2 - Understanding The Patient’s Perspective Is Vital

High performing physicians understand that in order effectively engage patients in their care they first need to understand what is important to them. This means
Only after the patient’s values and preferences have been clarified will the physician and patient be able to make truly collaborative decisions that are in the patient’s best interest.


Poor concordance between patient and physician regarding the standing medication regimen has been reported in a number of studies conducted in a variety of ambulatory settings, but mainly in primary care.

This suggests that poor communication is common and widespread—a problem that can be greatly exacerbated when there are frequent medication changes and cultural and language differences between patients and physicians.


becoming familiar over time with their health beliefs, fears, motivations and previous health experiences that collectively defines their health reality.

High performing physicians recognize that physicians tend to “get it wrong” when they make assumptions about their patients, e.g., their visit expectations, knowledge about their condition, desire for health information, adherence and so on. Rather than assume something and get it wrong, high performing physicians will ask the patient.

**#3 - Seeks Patient’s Agreement – Shared Decision-Making**

High performing physicians know that nothing good is going to happen if, upon leaving the office, the patient and physician are not on the same page. A disagreement between the physician and patient, spoken or unspoken, significantly increases the likelihood that patients will not pick up their new prescription medication or follow through with anything else they recommend.

Throughout the visit, high performing physicians are mindful of and responsive to patient “cues” that suggest a possible concern or lack of agreement by the patient.

These physicians understand that patients feel “cared about” when the physician probes at length when the patient has a concern. That patients like a physician who urges them gently to agree to important tests, medication, or procedures even though the patient is reticent.
When prescribing a new Rx medication, primary care physicians typically spend less than 60 seconds informing patients how to take new medications...or why.


#4 - Don’t Neglect The Patient’s Psycho-Social Needs

High performing physicians understand that anxiety, depression and other psycho-social issues are common in patients with multiple chronic conditions. They also recognize the importance of being aware of the patient’s health context. Do they live alone? Can they pick up or afford their medications?

As such, high performing physicians are more likely to recognize patients in distress and respond with empathy and support.

#5 - Don’t Underestimate The Patient’s Desire For Information...Even If They Don’t Ask Questions

High performing physicians know that the more patients know about their condition, the more adherent they are and the better their outcomes. They also understand that just giving a brochure or patient portal URL is not enough. Patients need training and support to build confidence in their own self-care management abilities.

With the right information, and guidance from their doctor, high performing physicians know that even initially non-adherent patients can be brought around.

These physicians recognize that is their job to not only prescribe a treatment. They must also help patients work through their “necessity/concerns analysis” by providing them with the information and support needed to arrive at a decision that works for everyone.
Physician Communication Skills Training Shown To Improve Patient Medication Adherence

Given the evidence linking suboptimal patient communications to medication nonadherence, does it follow that physicians can improve patient adherence by improving their patient communication skills?

Zolnierek and DiMatteo looked at 12 published studies involving the impact of communications training on medication adherence. Their findings revealed “substantial and significant improvements in patient adherence” as a result of brief communications training interventions.

Specifically they found that:

“Training physicians in communication skills improves patient adherence by 12%...the odds of patient adherence are 1.62 times higher with training than when a physician receives no training.”

Summary

Two patients each visit their physician with identical complaints and receive identical prescriptions, but only one fills the prescription. Why?

As this paper demonstrates, a big part of the answer to this question depends upon the physicians’ patient communication style and skills.
Specifically it depends upon their ability to:

1) Build a strong case with the patient concerning the necessity for taking action, e.g., take a new medication. This means eliciting the extent and accuracy of the patient’s knowledge about their diagnosis and its severity.

2) Provide the patient with the evidence needed to build trust in the safety and efficacy of the treatment recommendation. How do you know how much information to provide? Ask the patient.

3) Assess the patient’s level of agreement with their diagnosis, its severity, and the need for treating the problem.

4) Assess the patient’s level of agreement with their view of the safety and efficacy of the proposed treatment.

5) Help patients cognitively process points of disagreement with their diagnosis and/or treatment recommendations.

6) Work towards an agreement concerning treatments that are acceptable to both they and the patient.

The evidence shows that simply giving information about the new medication to the patients via a brochure or URL link to a patient portal is not enough. Physicians must help patients work through their understanding of the “necessity/concerns ratio” as described above in order to arrive at the best decision.
On approximately one third of hypertension-related visits, in which blood pressure was not controlled, the care provider did not even ask about medication taking, and closed-ended questions during the visit inhibited discussions on medications or medication-taking behaviors.


Preliminary evidence also suggests that there is a good business case to be made for improving patient medication adherence. **By improving the patient-centered communication skills of physicians through training, studies suggest that a 10% to 20% reduction in medication nonadherence...and the associated costs... is possible.**

This paper makes a compelling case for why provider and payer organizations should pay closer attention to the patient communication style and skills of the physicians in their provider networks.

**Mind The Gap Academy** offers a range of patient communication solutions for clinicians and the organizations they work for including:

- population health management services
- communication skills assessment and benchmarking services
- patient communications skills training programs

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www.MindtheGapAcademy.com

Or call

408-448-1537 (PST)
The Key To Better Medication Adherence Is Better Physician-Patient Communication

References


2 Heisler M, Actively Engaging Patients in Treatment Decision Making and Monitoring as a Strategy to Improve Hypertension Outcomes in Diabetes Mellitus, Circulation 2008;117;1355-1357


4 ibid


8 Ibid


14 Ibid


17 Ibid

18 Ibid


20 Wilkins, S. Mind the Gap 2010. www.mindthegapacademy.com
The Key To Better Medication Adherence Is Better Physician-Patient Communication


26 Ibid


28 Clifford, S. et al.

29 Sleath, B. et al.


31 DiMatteo, R. et al.