

Commentary for Medication Adherence of Patient Assistance Program Recipients: A Pilot Study

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It is commonly believed that if you give individuals financial incentives for a particular action they will be more likely to engage in that action. This concept of reward-behavior pairing stems from classic experimental research led by the Russian physiologist Ivan Pavlov and American Psychologist B.F. Skinner. Value expectancy theorists of the 1930's and 40's also supported similar concepts in the notion that individuals are more likely to engage in a particular behavior if they value the outcome of the behavior and believe it is likely that the behavior will result in the valued outcome. Predicated on these well accepted theories, it is reasonable to anticipate that financial incentives will lead to improved medication adherence behavior.

Conley and Hughes, however, found this is not necessarily always true. They found no significant differences in medication adherence between enrollment and 6 months post enrollment of a patient assistance program or receiving prescription benefits through a state's Medicaid program. Students of psychosocial behavior ask themselves why are such findings discrepant with theory and prior literature reviewed by the authors. Part of the explanation could be attributed to small sample size (lack of power), study measures, or other methodological issues.

However, patients may have been non-adherent due to other reasons. Barriers/perceptions toward continued medication use are dynamic and change over time due to various outcomes experienced and the alternatives available.¹ For example, the authors reported that those in the Patient Assistance Program experienced a decrease in motivation over time. The lack of motivation may have been due to side effects, lack of perceived need for the medication, the lack of a pharmacist-patient relationship, decreased self-efficacy in taking the medication, etc. In addition, the negative motivation may be due to changes in the perceived value of the medication given new alternatives that have come available and for which the patient desires change. The lack of interventions targeting these or other reasons may have contributed to the lack of change in adherence between baseline and 6 months post enrollment.

Clearly, to have an impact on medication adherence, we need to assess the reason for the non-adherence and creatively target it. We also need to appreciate that perceptions of continued medication use is a dynamic process that can change due to ongoing patient re-evaluation of outcomes and alternatives. "One size fits all and static" approaches are not likely viable and sustainable in improving medication adherence. The medication adherence research community has and continues to learn that, at the individual level, we need to tailor interventions across time to an individual's changing concerns and, at the population level, we need to segment the population to those most likely to have specific adherence barriers, target these barriers, and evaluate the effectiveness of such populations-based interventions.

¹Rickles NM. A multi-theoretical approach to linking medication adherence levels and the comparison of outcomes. *Res Soc Admin Pharm* 2010; 6:49-62.

Editor's Note: INNOVATIONS in pharmacy welcomes papers that generate new ideas and discussion about those ideas. The pilot study by Conley and Hughes provides this. We asked Dr. Rickles to write this commentary in order to add to this important discussion.