One in four patients does not follow the advice of his or her health care provider, according to recent research published in the March 2004 Medical Care. The analysis, which evaluated almost 600 studies conducted between 1948 and 1998, suggests that as many as 188 million medical visits per year result in patients failing to adhere to their providers’ recommended treatment regimens.

The cost of these visits can amount to a staggering $300 billion per year, according to the authors of the Medical Care study. Poor patient adherence is also potentially dangerous to patients’ health and poses challenges to the accuracy of clinical trials and other scientific research.

“What non-adherence with therapy is one of the most important contributing factors in poor treatment response and unnecessary health care costs for both adults and children,” says Cynthia Rand, Ph.D., professor of medicine at the Johns Hopkins School of Medicine.

What Is Patient Adherence?

Patient adherence is about more than blindly following doctors’ orders. According to Rand, it is a complex set of behaviors that require patients to know what their treatment regimen is, to be motivated to begin treatment, and to be satisfied with treatment after it has been attempted.

“Patients must know what to do, want to do it, and be able to do it,” says Robin DiMatteo, Ph.D., professor of psychology at the University of California, Riverside.

When people fail to follow their treatment protocol, they are not necessarily defying their doctors’ orders deliberately. Indeed, in many cases,
As I approach the end of my tenure as your board chair, I want to reflect on the state of AcademyHealth as it approaches its five-year anniversary. The board is now involved in a process designed to reflect and learn from the first five years in order to chart a course and meet the challenges facing AcademyHealth in the future.

This fall we have conducted a series of interviews with current and past board leaders as part of this effort. Board members have responded positively, noting especially AcademyHealth’s success in creating a new identity and launching a number of new and successful programs and initiatives.

In particular, board leaders cited the two excellent annual conferences—the Annual Research Meeting and the National Health Policy Conference—and our expanded cyber seminar series on methods. They also value the accomplishments that have been made by our Coalition for Health Services Research in advocating broadly for the field of health services research and national health data and statistics.

I further applaud several critical and proactive initiatives AcademyHealth has completed this year. The board has just ratified the new Ethical Guidelines for Managing Conflicts of Interest in Health Services Research after a two-year, voluntary effort by a high-level committee of your peers. And an equally prestigious committee will soon issue recommendations regarding the Placement, Funding, and Coordination of Federal Health Services Research. In addition, AcademyHealth is working hard to establish a Council of Sponsors of Health Services Research, comprised of the leaders of federal agencies and national foundations, to oversee the ongoing development of a strategic plan for the field.

As a member of the Joint Management Committee that oversaw the merger of the Association for Health Services Research and Alpha Center five years ago, it has been gratifying to see the progress we’ve made in realizing our mission to promote the use of research and information among health care decision makers and practitioners. As I said in my speech at the 2004 Annual Research Meeting in San Diego this past June, “This translational task is tough and important work. It frustrates, challenges, and inspires us.”

AcademyHealth will continue to face a variety of challenges in achieving its mission. However, if past is prologue, I look forward to AcademyHealth’s next five years as a major proponent for the translation of knowledge into health policy and practice. It has been a pleasure to serve as your chair.

David Blumenthal, M.D., M.P.P.
Partners HealthCare System

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**Dates to Watch**

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Application deadline for NCHS/AcademyHealth Health Policy Fellowship</td>
<td>2–3 2005 National Health Policy Conference (Washington, D.C.)</td>
<td>4 Deadline for nominations for 2005 AcademyHealth awards</td>
</tr>
<tr>
<td>14 Submission deadline for 2005 Annual Research Meeting abstracts (June 26–28, Boston)</td>
<td>31 Submission deadline for 2005 Child Health Services Research Meeting abstracts (June 25, Boston)</td>
<td>7 Submission deadline for 2005 Public Health Systems Research Interest Group Meeting (June 25, Boston)</td>
</tr>
<tr>
<td>31 Submission deadline for 2005 Child Health Services Research Meeting abstracts (June 25, Boston)</td>
<td></td>
<td>18 2005 Annual Research Meeting abstract notifications issued</td>
</tr>
<tr>
<td></td>
<td>4 Health in Foreign Policy Forum (Washington, D.C.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Minicourses: Health Policy Tools and Techniques (Washington, D.C.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>22 Deadline for Board of Director nominations</td>
<td></td>
</tr>
</tbody>
</table>
Continued from Adherence, page 1

patients do not understand the dosing regimen, the rationale for therapy, or the treatment instructions. They may not comprehend the difference between chronic and acute therapies, for example, and thus take the wrong medication at the wrong time.

In other instances, patients consciously choose not to comply, perhaps because they cannot afford treatment, don’t believe the treatment will be effective, or are afraid of addiction or side effects. They might also be reluctant to engage in established medical practices due to cultural or religious beliefs, or simply have a preference for alternative therapies.

Improving the Doctor-Patient Relationship
Regardless of patients’ reasons for non-adherence, providers need to be part of the solution. Research indicates that poor patient-provider communication is perhaps the single biggest deterrent to patient adherence. Multiple studies show that patients report recalling and comprehending as little as 50 percent of what they have been told by their providers during a medical visit, says Rand.

Moreover, she continues, physicians do more than 60 percent of the talking during a patient visit, and much of that is focused on biomedical issues that patients may not understand rather than on psychosocial issues that could improve their adherence. About 50 percent of the time, physicians do not even name the medicine that patients are expected to take or give dosing instructions, Rand says.

Many researchers champion a collaborative approach to communicating with patients, which includes: providing clear instructions about the treatment and its purpose; acting in an approachable, supportive manner; soliciting and listening to patients’ views and concerns; and engaging in participatory problem-solving.

“Patient outcomes are enhanced when the physician engages the patient comprehensively, behaviorally, and cognitively,” says Debra Roter, Ph.D., who conducts a physician training program at Johns Hopkins and advocates a patient-centered approach in which physicians build partnerships with patients and negotiate treatments with them.

Having adequate social support also increases the likelihood that patients will adhere to their treatment plan. Patients can benefit from both practical and emotional support from their spouse, family, and friends. Studies suggest that, when it comes to patient adherence, the particular configuration of a patient’s social network—for example, whether he or she is married—does not matter as much as the quality of the relationships within that network, and the practical and emotional support derived from others.

Who Is Most at Risk?
Failure to take medications as prescribed poses a special risk to the elderly, who tend to be frail and have multiple conditions. Compounding the problem, many older adults can’t afford to pay for all of their prescribed medications because they are on fixed incomes and/or lack comprehensive health care coverage. A study in the July/August 2003 Health Affairs found that, over a two-year period, more than two million Medicare beneficiaries did not adhere to their prescribed drug treatment regimen due to cost concerns.

Hopefully, the recent Medicare prescription drug benefit, which will take effect in 2006, will help reduce some of those cost barriers. However, only time and research will reveal the impact of the new legislation on beneficiaries’ ability and willingness to receive appropriate care.

Treatment adherence is also an important issue for individuals with chronic conditions such as diabetes or heart disease. Over the next 30 years, the number of chronically ill Americans is expected to increase by 37 percent. Many people with such conditions visit multiple physicians and receive conflicting advice, making it difficult for them to get the full benefit of treatment.

A Role for Research
“As we move forward, patients will need to play a more active role in managing their health and health care,” says Janet Corrigan, Ph.D., director of the Board on Health Care Services at the Institute of Medicine. Health services research will be critical in order to flesh out whether new, more patient-centered models of care management and health education can help patients navigate more easily the best treatment path.

Research is also needed to evaluate improvements in technology that could enhance patient adherence. Providers are already experimenting with technological innovations such as “smart” pillboxes that remind patients with a beep when it is time to take their medicine. Increasingly, patients with chronic illnesses such as diabetes are using palm digital assistant-based technologies to monitor dietary intake, medication, and blood glucose levels.

“Patient adherence is a critical missing piece in the health care delivery puzzle,” says AAPA Executive Vice President Stephen Crane, Ph.D. “If we made no other change in the health care system but to work on adherence, we would be able to make a very big difference in health care outcomes.”

Further Reading


Consumer-Driven Health Plans: Potential, Pitfalls, and Policy Issues

The Robert Wood Johnson Foundation’s Changes in Health Care Financing and Organization (HCFO) and State Coverage Initiatives (SCI) programs recently hosted a cyber seminar to share updated HCFO-sponsored research on consumer-driven health plans (CDHPs) and explore the policy implications of such plans. The seminar, titled “Consumer-Driven Health Plans: Potential, Pitfalls, and Policy Issues,” is available online at www.hcfo.net/cyberseminar/0904/index.htm.

The CDHP model commonly comprises three elements: 1) a personal account funded in a variety of ways to pay for health care; 2) a high-deductible plan; and 3) decision-making tools. Because CDHPs give consumers more control over how their health care dollars are spent, some experts believe the plans will lead people to make smarter choices and thereby curb rising health care spending. However, others fear that CDHPs’ high deductibles and out-of-pocket costs could prevent patients from receiving necessary care and increase expenditures in the long run.

“Greater employee cost-sharing in the form of premiums, deductibles, and co-insurance is being felt across all plans,” says Anne K. Gauthier, AcademyHealth vice president and director of the HCFO program. “CDHPs may provide an opportunity for consumers to better manage those costs, but only time and research will tell.”

“CDHPs may provide an opportunity for consumers to better manage costs, but only time and research will tell.”

– Anne Gauthier, AcademyHealth vice president

CDHPs might also lower pharmaceutical expenditures, according to new research presented by Steve Parente, Ph.D., and colleagues at the University of Minnesota; it looked at employees of a large employer who were given the choice among a health maintenance organization (HMO), a preferred provider organization (PPO), or a CDHP. Individuals enrolled in a CDHP had lower pharmaceutical expenditures over time than those in an HMO or PPO, but came in second for pharmacy

AcademyHealth Partners with CDC to Highlight Value of HSR

AcademyHealth has partnered with the U.S. Centers for Disease Control and Prevention (CDC) to highlight several examples of health services research (HSR) that has been translated into policy. CDC research conducted over the past 20 years, for instance, has shown that health care workers are at increased risk for contracting blood-borne infections through accidental injuries with needles or other sharp objects; CDC has used this body of evidence to help hospitals nationwide implement and evaluate injury prevention strategies, such as safer devices, education, and practice changes.

This research was the focal point of one of AcademyHealth’s recent “Health Services Research Impacts,” a series of information sheets designed to highlight the value of HSR for policy professionals, funders, and other decision makers. AcademyHealth collaborated with CDC this year to produce two new impacts on “Health Care Worker Safety” and “Quality and Safety.” They are available at www.academyhealth.org/connectingthedots/impacts.htm.

The second CDC impact, released earlier this year, emphasizes how CDC research into health care-associated infections has yielded strategies that combine monitoring, prevention, and control of such infections. Over the past decade, hospitals that participated in a CDC-sponsored surveillance system, which helps hospitals monitor trends in health-care associated infections, experienced a 30 to 55 percent decline in targeted infections in intensive care units.

AcademyHealth would like to build partnerships with other organizations that conduct or fund HSR in order to communicate the importance of our field. To find out more, contact Stacia Sanvik at 202.292.6700.

In addition, AcademyHealth will launch a new awards program in 2005 to recognize specific research or a body of research that has significantly affected health and health care. Starting next year, AcademyHealth will issue a call for nominations to its membership, and an advisory committee will select one or two research impacts. Each year, the winners will be announced at the annual National Health Policy Conference and the winning research impact will be published and widely disseminated through our Health Services Research Impacts series. Look for further information about the award in an upcoming AcademyHealth Reports.
States and Medicare Part D: More Questions than Answers

A year after the Medicare prescription drug legislation was signed into law, state officials are still sorting out its implications for their budgets and public programs. On October 7–8, AcademyHealth and the Rutgers Center for State Health Policy held an invitational summit in Philadelphia to explore state policymakers’ choices and issues about implementing Medicare Part D. The meeting provided an opportunity for states to share lessons about implementing Medicare’s drug discount card program, and to communicate directly with officials from the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration (SSA).

The new benefit will significantly affect “dual eligibles”—individuals who qualify for both Medicaid and Medicare. As of January 2006, this group will no longer be eligible for Medicaid-financed prescription drug coverage. Instead, many low-income dual eligibles will be auto-enrolled into the voluntary Medicare program; others, including those currently enrolled in Medicaid assistance programs such as the Qualified Medicare Beneficiary program—as well as those in nursing facilities—will also be eligible for Part D but will need to enroll on their own.

Under the law, CMS and SSA must approve individuals’ eligibility for Part D. However, the details of the new administrative structure have yet to be worked out. Some fear that dual eligibles could end up without any prescription drug coverage during the hectic period of transitioning to the new program. “Medicaid prescription drug coverage stops January 1, 2006, whether consumers, states, or prescription drug plans are ready or not,” says Ohio Medicaid Director Barbara Coulter Edwards.

Implementing some facets of Part D will be particularly difficult considering that state Medicaid budgets for 2006 are projected to be even tighter than they are now. For example, officials are concerned with the “clawback” feature in the Medicare legislation, which requires states to repay the federal government a substantial portion of their savings from financing drugs for dual eligibles once the new program is implemented. The formula that states must use to determine savings is based on a 2003 baseline of states’ Medicaid drug expenditures for dual eligibles—which could, some policymakers believe, hold states to a higher-than-actual level of spending.

“I don’t think anyone’s base year will reflect the way things will be done in 2006,” according to one Medicaid director whose interview was cited by Vernon Smith, Ph.D., of Health Management Associates.

Moreover, many policymakers are anticipating that states will be further crunched financially due to the “woodwork effect”—a surge in Medicaid enrollment that may occur as more low-income Medicare beneficiaries realize that they are eligible for drug coverage.

States that already operate state-only prescription drug programs must also sort out whether, and how, to coordinate their existing program with the new benefit. According to Jack Hoadley, a researcher at the Georgetown University Health Policy Institute, states have three options: 1) to fill in gaps in Part D coverage by “wrapping around” it with their own coverage; 2) to maintain their programs as an alternative to part D; or 3) to drop their programs altogether.

Each approach has advantages and drawbacks that states need to explore. For example, many officials like the idea of filling in gaps or subsidizing payments so that low-income Medicare beneficiaries have more comprehensive coverage. However, states would need to put more of their own dollars at stake to do this, as they cannot receive a federal funding match for wrapping around Part D.

States clearly have more questions than answers about the new benefit at this point. However, the meeting represented a significant step toward clarifying the issues so that both states and federal officials can prepare effectively for this critical transition. For an agenda and presentation slides from the meeting, visit www.statecoverage.net/medicarepartd/agenda.htm.

Implementing the New Drug Benefit: What Will It Take?

- Effective coordination among states, the Centers for Medicare and Medicaid Services, and the Social Security Administration to determine eligibility and enrollment;
- Appropriate exchange of data between states and prescription drug plans;
- Expedited transfer of relevant research into policymakers’ hands;
- Making difficult choices about whether (and how) to supplement the federal benefit;
- Effective communication with service recipients (including providing proper training for staff), between state and federal agencies, between states and insurers, and between researchers and policymakers.
Members Elect Lillie-Blanton and Weisman to Board

AcademyHealth is pleased to welcome two new directors to its board: Marsha Lillie-Blanton, Ph.D., of the Henry J. Kaiser Family Foundation, and Carol Weisman, Ph.D., of the Pennsylvania State University College of Medicine.

Dr. Lillie-Blanton directs the Kaiser Foundation’s policy research on access to care for vulnerable populations. Her research and policy interests are in the areas of substance abuse, racial/ethnic minority health, and HIV/AIDS. She serves on The Robert Wood Johnson Foundation’s Changes in Health Care Financing and Organization (HCFO) initiative’s national advisory committee.

Dr. Weisman is a sociologist and health services researcher with a principal interest in women’s health. Her research focuses on access and quality in women’s primary and preventive care. She worked with staff at the Agency for Healthcare Research and Quality to propose the initiation of the women’s health theme for the Annual Research Meeting. She is the founding member of AcademyHealth’s women’s health interest group.

“We are very pleased to welcome these distinguished women to our board of directors,” says Gail Wilensky, Ph.D., who chairs AcademyHealth’s Nominating Committee. “Their experience in and service to health services research and health policy will help guide our organization through the challenges of 2005 and beyond.”

The Process

In June, the AcademyHealth Board of Directors approved the Nominating Committee’s slate of four candidates for the member election. In selecting these candidates, the Committee strove to bring diversity and expertise to the Board and strike a balance between continuity and new leadership.

The all-electronic member election was held from September 7–24, 2004. Members received instructions by e-mail and postal mail, and all voting took place on the secure voting Web site. At 5:30 p.m. on September 24, the voting site was closed. There were 3,621 eligible voters, of whom more than 34 percent cast a ballot.

Also in June, the board elected three new directors: Margarita Alegria, Ph.D., Center for Multicultural Mental Health Research, Cambridge Health Alliance; John Colmers, M.P.H, Milbank Memorial Fund; and Nelson Ford, Humana, Inc. According to AcademyHealth bylaws, the number of member-elected and board-elected candidates should be approximately equal each year. Next year, there will be three member-elected and two board-elected directors.


Get Involved

Members’ input is critical as AcademyHealth looks each year to select new leadership.

In the 2004 election, we solicited feedback from our voters through a short survey on what prompted them to vote: e-mail instructions, mail instructions, or both. Nearly 80 percent responded that they voted after receiving e-mail instructions. If you have other ideas about how to make the process better, please let us know by contacting Kristine Metter, director of membership, at kristine.metter@academyhealth.org.

For more information about the new board members, visit: www.academyhealth.org/about/board.htm.
members matter

Moving On and Moving Up
Keep in touch with friends and colleagues by sending your career news to membernews@academyhealth.org. Submissions of no more than 25 words will be printed on a first-come, first-served basis.

Ty Borders, Ph.D., is now associate professor of health management and policy at the University of North Texas School of Public Health.

Meg Bourbonniere, Ph.D., R.N., has joined Yale University’s School of Nursing as assistant professor.

Deena J. Chisolm, Ph.D., has been appointed clinical assistant professor in the Office of Clinical Sciences at the Columbus Children’s Research Institute.

Mark R. Coin, M.P.H., has accepted a position as director of public policy for Merck & Co., Inc.

Juliette Cubanski, Ph.D., M.P.H., has accepted a position as senior policy analyst for the Kaiser Family Foundation Medicare Policy Project.

Tim Cuerdon, Ph.D., has accepted a position as senior associate, health services research, for the American College of Physicians.

Douglas E. Hough, Ph.D., was promoted to associate professor and continues as chair, The Business of Health, School of Professional Studies, Johns Hopkins University.

Katherine R. Jones, Ph.D., R.N., has been appointed acting dean at the Yale University School of Nursing.

Anthony T. Lo Sasso, Ph.D., recently joined the Division of Health Policy and Administration in the School of Public Health at the University of Illinois at Chicago as an associate professor.

Hongdao Meng, Ph.D., became assistant professor in the Department of Medicine at Stony Brook University.

Janet Myers, Ph.D., M.P.H., is now assistant professor of medicine and co-director of the AIDS Policy Research Center, University of California, San Francisco.

Paul A. Nakonezny, Ph.D., M.B.A., has joined The University of Texas Southwest Medical Center at Dallas as assistant professor in the Biostatistics and Clinical Science Department.

Casey L. Nelson, Pharm.D., has joined Blue Cross and Blue Shield of Nebraska as a managed care resident.

Jennifer Schultz, Ph.D., has a new appointment as an associate professor in the Department of Economics and is the director of the Health Care Management Program in the School of Business and Economics at the University of Minnesota, Duluth.

Joanne E. Spetz, Ph.D., has been promoted to associate professor in the Department of Community Health Systems at the University of California, San Francisco.

Robert Weech-Maldonado, Ph.D., M.B.A., has joined the University of Florida’s Department of Health Services Research, Management, and Policy as associate professor.

News from the Journals

Health Affairs
The January/February issue of Health Affairs will be a special theme issue on evidence-based medicine. In addition to multiple articles relevant to that topic, the issue will feature the federal government’s annual health spending statistics and a piece assessing the impact of hospital system expansion on consumers.

HSR
The December Health Services Research includes articles addressing people living with chronic illness, quality of care, risk selection, and vulnerable populations. There is also a special issue on Global and International Health with articles on cross-country comparisons, global issues in public health, reproductive health in today’s world, and national lessons on the financing of health care.

Milbank Quarterly
The December Milbank Quarterly includes a systematic literature review of the diffusion of innovations in service organizations, as well as articles on evidence-based treatment for depression in primary care practice, the implications for evidence-based medicine on treatment response, the extent to which the workers’ compensation system covers chronic disease resulting from occupational exposures, and more.

Coming Soon — AcademyHealth Ethical Guidelines
AcademyHealth is proud to release its Ethical Guidelines for Managing Conflicts of Interest in Health Services Research, which will be available on our Web site (www.academyhealth.org) within the next few weeks. AcademyHealth’s Ethical Guidelines Committee, chaired by Ezekiel J. Emanuel, M.D., Ph.D., Director, Department of Clinical Bioethics at the National Institutes of Health, has developed these guidelines to generate dialogue and serve as a resource for preventing and resolving conflicts of interest while sustaining viable research programs in diverse organizational environments.
As the 2004 presidential campaigns made clear, health and health policy remain issues of critical importance to the American people. Much of the domestic debate focused on medical malpractice reform, Medicare coverage, and consumer-driven health plans. On February 2–3, AcademyHealth and Health Affairs will put those and other important policy issues in context for 2005 at the fifth annual National Health Policy Conference (NHPC) in Washington, D.C.

Mark McClellan, M.D., Ph.D, administrator of the Centers for Medicare and Medicaid Services, will begin the conference with a plenary on the administration’s health policy agenda for 2005. Other experts will offer perspectives from Congress, states, academia, and the private sector.

Minicourses on Health Policy Tools and Techniques
Following the 2005 National Health Policy Conference on February 4, AcademyHealth will offer two minicourses on health policy tools and techniques. Designed for policy professionals at all levels, the three-hour workshops highlight how research informs policy. The first, offered from 9 a.m. to 12 p.m., addresses how cost estimates are made and used for congressional funding decisions. The afternoon minicourse, which begins at 1 p.m., covers what policy professionals need to know about risk adjustment methods, which are rapidly replacing traditional actuarial and medical management tools for purchasers and managed care plans.

Health in Foreign Policy Forum
In an increasingly global world, the intersection between health and foreign policy has become an important area that experts from both fields need to better understand. AcademyHealth will launch its first Health in Foreign Policy Forum on February 4 from 8:30 a.m. to 5:30 p.m. The Forum will focus on global commerce and health; disease and national security; and international development and public health preparedness.

To register or learn more about the National Health Policy Conference, minicourses, or Health in Foreign Policy Forum, visit www.academyhealth.org/nhpc/index.htm.