PHARMACY BENEFIT INTEGRATION AND ADHERENCE TO EVIDENCE-BASED MEDICINE IN A COMMERCIALLY-INSURED POPULATION

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OBJECTIVES: The purpose of this analysis was to determine if integration of pharmacy benefits had an impact on the number of gaps in evidence-based care experienced by individuals and the number of gaps in care that those individuals close.

METHODS: Data on 262,000 individuals with coverage in 2008. Participants had to have 12 months of continuous enrollment in order to be included in the analysis. Matching on age, gender, and health risk was performed to partially adjust for differences between integrated and carve-out employers. A two-part regression model was then used to identify differences in the likelihood of the two groups to adhere to evidence-based standards, and in the number of gaps in care that they would experience, while controlling for additional factors such as participation in outreach programs and plan design.

RESULTS: Participants with integrated pharmacy benefits had a higher rate of gaps in care (odds ratio 1.04, 95% CI 1.014–1.064), although the numbers of gaps experienced were lower (4.78 [95% CI 4.77–4.81] vs. 4.87 [95% CI 4.83–4.89]) in integrated plans vs. carve-out. While controlling for the initial number of open gaps, the likelihood of gap closure was higher in integrated plans than in carve-outs (odds ratio 1.028 [95% CI 1.003–1.054]). The number of gaps closed was also higher (2.13 [95% CI 2.13–2.13] vs. 2.01 [95% CI 2.01–2.01]) in integrated vs. carve-out.

CONCLUSIONS: Higher rates of evidence-based gap closure are associated with individuals that participate in health plans with integrated pharmacy benefits when compared to individuals with carved-out plans.

RATIONAL USE EFFECTS OF IMPLEMENTING AN ESSENTIAL MEDICINES LIST

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OBJECTIVES: Develop an essential medicines list (EML) in 2000 to improve rational use of medicines and contain costs in Middle East-Palestine. METHODS: We examined the effects of the EML in the Palestinian health care public sector. We obtained data on prescription patterns for medicines from 3370 prescriptions given during outpatient visits at 17 health care facilities in the West Bank from 1997 to 2001. We calculated the prescriptions to measure rational use. We modeled indicators of rational use as a function of the EML and 16 health center indicator variables. RESULTS: The EML was effective in shifting all prescribing indicators toward standard values. To OBJECTIVES: Adherence was lower in a few drug classes among patients who enrolled in consumer-driven health plans.

ASSESSMENT OF PHARMACOECONOMIC EVALUATIONS SUBMITTED FOR REIMBURSEMENT SINCE KOREAN POSITIVE LIST SYSTEM INTRODUCTION

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OBJECTIVES: We assessed the quality and characteristics of pharmacoeconomic evaluations for reimbursement since the Korean positive list system introduction. METHODS: Twenty-four submissions with pharmacoeconomic evaluation (PE) were submitted in this study, which are new medicines evaluated by Drug Benefit Coverage Assessment Committee (DBCAC) from introduction of positive list system to June 30th in 2009. We evaluated them with HIRA PE checklist consisting of 21 items which was developed for assessing the appropriateness according to the guideline of pharmacoeconomic evaluation in Korea and QHES checklist. RESULTS: Twenty-four submissions were evaluated as Cost Minimization analysis (n = 16), 66.6%, Cost Effectiveness analysis (n = 4), 16.7% and Cost-Utility analysis (n = 4, 16.7%). On the average, 15 among 21 items of HIRA PE checklist were fulfilled (73%, range 52.4–100%) and quality assessment score by QHES was 62.1 (range 31–97). The items which submissions mostly followed were presenting analysis perspective, disaggregated incremental cost-effectiveness ratio, appropriate selection of primary outcome and discount rate of cost and effectiveness. The issues noted as inadequate submissions were obscure process of cost and effectiveness data, cost estimation sufficiency, identification of uncertainty analysis and incremental cost-effectiveness ratio per QALY (n = 4) showed from 8K to 59K USD. DBCAC didn’t evaluate cost-effectiveness with explicit threshold values and decisions considering ICER were made by deliberating on the uncertainty surrounding them as well as disease severity, societal burden, quality of evidence, nature of innovation and innovative nature of the study could be helpful for understanding present state of pharmacoeconomic evaluation submitted since the introduction of Korean positive list system and valuable for suggesting items required to be improved for appraisal.

WILLINGNESS TO PAY FOR PHARMACY SERVICES: A REVIEW

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BACKGROUND: Quantifying the value of pharmacist-provided services beyond dispensing is imperative for the profession of pharmacy as it works to establish a bulwark within the evolving health care system. To date, the preponderance of research has focused on evidence of pharmacist-provided services included. RESULTS: Twenty-three studies were identified using the search strategy outlined. Eighteen pharmacist-provided services were assessed in a variety of demographic and geographic populations. Studies were appraised using the 1993 NOAA panel recommendations for the contingent valuation method. Most studies published before 1999 tended to use less standardized methods and typically did not conform to NOAA panel recommendations, whereas those published after 1999 tended to have greater methodologic and statistical rigor. CONCLUSIONS: Surprisingly few published studies have employed the contingent valuation method to assess consumers’ perceptions of pharmacist-provided services. Improving the quantity and quality of such studies will aid the profession in marketing pharmacy services to consumers. Understanding the pharmacy services that consumers’ value and their willingness-to-pay for those services will be...