REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-11

Subject: Consumer Medication Information

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Referred to: Reference Committee E
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INTRODUCTION

A considerable amount of attention has been devoted recently to the issue of patient adherence, the extent to which patients take medications as prescribed by their physician. Many physicians may be more familiar or comfortable with the term "compliance" when assessing the extent to which patients' behaviors coincide with their advice and the prescription drug label instructions. The term "adherence" has gradually replaced "compliance" based on the view that it implies a more collaborative relationship and may be more respectful of the patient's role in the whole process; however, both terms continue to appear in the literature. The term adherence will be used in this report.

Regardless of terminology, treatment plans are based on a therapeutic alliance established between the patient and the physician. Poor medication adherence contributes significantly to medication-related hospital admissions in the United States, at an estimated cost of at least $100 billion annually.[1] Compared with adherent patients, those with chronic disease who are poorly adherent to medication treatment plans have almost twice the annual health care costs, suffer increased mortality, and experience more frequent hospitalizations.[2-6] Overall, patients who do not take their medication as prescribed cost the health care system nearly $300 billion each year in otherwise avoidable medical spending, or approximately 13% of total health care expenditures.[7]

More specifically, nearly 75% of Americans report they do not always take their medications as directed; one in three never fill their prescriptions; and proper adherence approaches only 50% to 65% in patients with chronic conditions such as diabetes and hypertension.[5,6] Because it is widely accepted that approximately 75% of US health care spending is devoted to the treatment of chronic disease, the health care costs associated with poor adherence are a significant issue and underscore the particular vulnerability of such patients to poor adherence and the repercussions of this behavior.[8]

Patients report various reasons for not taking their medications as prescribed. One set of variables is related to uncertainty or lack of information about instructions and/or a lack of patient understanding or belief in the value of medication. Accordingly, the provision of consumer medication information (CMI)[†] is an important determinant of patient adherence.

[†] Some refer to this as written patient medication information or PMI. The term CMI will be used in this report.

This report will examine the regulatory history of CMI in the United States, examine deficiencies in the current system, and describe recent attempts to streamline and improve the content and value of CMI. Recommendations for bringing AMA policy on CMI up to date and promoting advancement in this field for the benefit of physicians and their patients are offered.

HISTORY OF CONSUMER MEDICATION INFORMATION IN THE US

Patient Package Inserts

Since 1968, Food and Drug Administration (FDA) regulations have required that patient package inserts (PPIs), written specifically for patients, be distributed when certain prescription drugs or classes of prescription drugs are dispensed. PPIs for estrogens (21 CFR 310.515) and oral contraceptives (21 CFR 310.501) are FDA-approved and are part of the product labeling. They must be given to the patient when the product is dispensed. Other PPIs (e.g., Epoetin®) are submitted to FDA voluntarily by manufacturers and approved by FDA, but their distribution is not mandated by regulation. The FDA also can require a PPI as part of a risk evaluation and mitigation strategy (REMS).

Consumer Medication Information

In the 1970s, the FDA began evaluating the general usefulness of patient labeling and, despite opposition from the Pharmaceutical Research and Manufacturers Association (PhRMA), AMA, and national pharmacy associations, the FDA proposed a regulation that would have required written patient information similar to the product labeling for all prescriptions.[10] These regulations were finalized in 1980 but later revoked in September1982 based, in part, on assurances that the effort could be handled more efficiently within the private sector.[11,12] In 1982, the National Council on Patient Information and Education (NCPIE) was formed to coordinate this effort (www.talkaboutrx.org). The AMA was a charter member of NCPIE but also acted independently for a period of time with its own "Patient Medication Instructions" leaflet program. Unfortunately, few physicians purchased the AMA's leaflets and the program was disbanded in the early1990s. What eventually evolved (still in place today) is an activity driven by private sector vendors who develop CMI based on the language in the FDA-approved product labeling, and under contract, deliver the text and format to pharmacies or pharmacy chains. The pharmacist then prints the CMI and delivers it at the point of dispensing after the prescription has been filled and purchased. Accordingly, the actual format and content of CMI for the same drug differs based on the vendor and pharmacy, and the pharmacy itself will sometimes edit the document to reformat or truncate it in some fashion.

New Performance Requirements for CMI

In the 1990s, the FDA began asserting that the private sector was not providing sufficient medication information to patients. In 1995, the FDA issued a Proposed Rule that would allow it to require some "high risk" drugs to have FDA-approved Medication Guides (MedGuides) that manufacturers would develop and pharmacists would dispense to patients with the prescription drug.[13] PhRMA, AMA, the National Association of Chain Drug Stores, the American Society of HealthSystem Pharmacists, and many other groups representing health professionals and industry vigorously opposed this Proposed Rule. Ultimately, Congress articulated the role of the private sector with the enactment of Pubic Law 104-180 that governs CMI.[14] Under PL 104–180, prescription drug information is developed and distributed by the private sector and the development of this information is voluntary. However, this law adopted certain performance goals and timeframes consistent with FDA's proposed rule in 1995 as follows:

- By the year 2000, 75 percent of people receiving new prescriptions would receive "useful" patient information with their prescriptions;

- By the year 2006, 95 percent of people receiving new prescriptions would receive "useful" written patient information with their prescriptions.

Thus, the law put the burden on the private sector to come up with a plan to improve its performance and authorized the Department of Health and Human Services (HHS) to organize the effort. This led to the Keystone Committee,[‡] which included the AMA and many other national organizations. The Committee ultimately created an "Action Plan for the Provision of Useful Prescription Medicine Information."

Keystone was intended to get consensus among all stakeholders on what to do regarding informing patients about their medicines; however, consensus was never reached. Consumers wanted full FDA control, some pharmacists wanted their oral counseling to become mandatory, and others believed the report was too prescriptive. The AMA and several national medical specialty societies submitted a letter of opposition to the Keystone recommendations. Ultimately, the action plan was submitted to the Secretary of HHS, who accepted the private sector plan in January 1997. The law required HHS to review the status of private sector initiatives designed to achieve the goals of the action plan and the FDA was charged with evaluating the private sector's progress in meeting these goals. The "usefulness" of medication information would be based on scientific accuracy, unbiased content and tone, sufficient specificity and comprehensiveness, literacy, timeliness, and an ability to enable consumers to use the medicine properly and appropriately, thus receiving the maximum benefit and avoiding harm.

Failure of CMI to Meet the Keystone Standards

According to the FDA, the current CMI process has failed to meet the statutory goals based on two commissioned independent evaluations performed in 2001 and 2008. In the 2001 evaluation, 89% of patients received some form of information, with 50% of this information determined to be useful.[15] In response, the FDA issued additional guidance in 2006 entitled "Useful Written Consumer Medication Information (CMI)."[16] The second CMI evaluation, conducted in 2008, found that patients received information 94% of the time, but only 75% of that information was deemed useful, falling far short of the goal set out in Public Law 04–180 that 95 percent of consumers would receive useful prescription drug information by 2006.[17] These findings set the stage for an FDA overhaul of the CMI system.

Medication Guides

Following the previously mentioned 1995 Proposed Rule, the final rule establishing Medication Guides was published in 1998.[18] Medication Guides are considered part of the official product labeling and are intended to address safety issues/adverse reactions that are specific to particular drugs, or in some cases, drug classes (e.g., antidepressants, nonsteroidal anti-inflammatory drugs).

Medication Guides are developed by manufacturers, reviewed and approved by FDA, and are required to be distributed with each prescription. When Congress amended the Federal Food, Drug, and Cosmetic Act in 2007, it included Medication Guides as one potential element of a

[‡] Steering Committee for the Collaborative Development of a Long-Range Action Plan for the Provision of Useful Prescription Information

REMS. The FDA may require a sponsor to develop a REMS if it determines a REMS is necessary to ensure that the benefits of a drug outweigh the risks. Through February 2011, the FDA approved 180 REMS that, with few exceptions, include a Medication Guide; approximately two-thirds of approved REMS consist of a Medication Guide only.

The AMA and many others have criticized the content, format, literacy, and clinical usefulness of Medication Guides, which are risk-based documents emphasizing potential harms to the exclusion of benefit information. Many patients do not understand Medication Guides, may not be receiving them, and their stark warnings may harm the patient-physician relationship in some circumstances by causing patients to forgo potentially beneficial treatment.

AMA POLICY

The AMA has three policies relevant to CMI: H-115.981, FDA Mandated Patient Information Sheets; H-115.995, Patient Instructional Leaflets (PIL); and H-120.967, Dispensing of Computer Generated Drug Information (AMA Policy Database). Some elements of these policies are not consistent with current regulations and/or do not reflect contemporary practice and/or physician attitudes; additionally, some are not patient friendly.

Policy H-115.981 is no longer relevant. PPIs are required for oral contraceptives and estrogen containing products and many other PPIs are now developed in a voluntary manner. Some elements of H-115.995, which address CMI materials, remain relevant, such as emphasizing that CMI is one element in the communication process, it should be concise but contain fair balance of benefits and risks, and should serve as an educational adjunct to the physician's instructions. This policy also opposes "unilateral development (of CMI) by the federal government," and states CMI development should be a cooperative effort of medicine and pharmacy; nowhere are manufacturers or the FDA mentioned.

Policy H-120.967 remains highly relevant and provides the platform for the genesis of this report. This policy urges the AMA to monitor the ongoing re-evaluation of how consumer medication information is designed and provided in the US and provide input to ensure that such documents are clinically useful, written at the appropriate literacy level, and promote patient adherence. The AMA is a founding member of NCPIE and has been on its Board since 1982. NCPIE is a coalition of over 80 diverse organizations whose mission is to stimulate and improve communication of information on appropriate medicine use to consumers and healthcare professionals. NCPIE has developed and published "Enhancing Prescription Medicine Adherence: A National Action Plan." (www.talkaboutrx.org/documents/enhancing_prescription_medicine_adherence.pdf). This report contains 10 recommendations to improve patient adherence in the US and has served as a catalyst for action across the continuum of care. NCPIE has several other video, electronic, and print materials on various topics related to patient medication information, including the AMA's Medication Counseling Guidelines which are freely available (http://www.talkaboutrx.org/educational_resources.jsp?rtype=resources1).

RE-EXAMINING PATIENT MEDICATION INFORMATION

Based on the fact that the voluntary CMI program failed to meet Congressional goals, along with the widely acknowledged shortcomings of Medication Guides and the existence of yet a third category of patient medication information (PPIs), the FDA is re-examining the development and dissemination of patient medication information for prescription drug products.

In 2008, a Citizen Petition was submitted to the FDA calling for adoption of a "one-document-solution" to replace the current plethora of CMI, PPI, and Medication Guides. In February 2009, the FDA's Risk Communication Advisory Committee recommended that the FDA pursue a "single-document" solution to PMI. The FDA held a public workshop in September 2009 that included the AMA to discuss the single-document pathway, examine prototype leaflets, and provide feedback. In May 2010 the Agency announced the design of an evaluation strategy for 3 CMI prototypes. Under contract with the FDA, the Brookings Institute convened an expert panel to discuss issues relevant to the science of communicating medication information to patients and followed up that exercise with a public stakeholder meeting in October 2010 on ensuring access to useful CMI. More recently, the Institute devoted time to designing a pilot evaluation for the distribution of standardized CMI.

SUMMARY AND CONCLUSION

Typically, physicians provide oral counseling that may be reinforced by CMI provided at the site of dispensing, or more complex risk-based documents such as Medication Guides. Recently, the FDA determined that the private sector has not met its obligation to provide useful medication information at the point of dispensing and is currently re-examining the issue of CMI in an attempt to move towards providing medication information in a format which is comprehensible, concise, and balanced. If done correctly, such a document could prove to be a valuable tool in assisting physicians to fulfill their obligations to educate their patients and move them on the path to medication adherence. High quality communication between patients and their physicians can promote safe and appropriate medicine use.

Patients currently may receive multiple documents with their prescription drugs from the pharmacy or clinical site of care, information that is developed and distributed through various sources. In order to make informed decisions about health care, patients need easy access to up-to-date and accurate information about the risks and benefits of the prescription drugs they take. Many factors impact the comprehension of patient information including use of less complex terminology, use of appealing section headings and graphics, and clear signals on the most important information. Patients need access to written prescription drug information that is accurate, balanced, and delivered in a consistent format. Development of new prescription drug patient materials should be based on user-testing that focuses on utility to the patient and comprehension of materials in the broadest audience possible.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be filed:

1. That Policy H-120.967, Dispensing of Computer Generated Drug Information, be reaffirmed (Reaffirm HOD Policy).

2. Our AMA supports the following basic principles for supplying written prescription drug information to patients: That (1) the AMA support the pursuit of a single document for the provision of written consumer medication information (CMI), replacing the current framework of patient package inserts, pharmacy generated prescription drug leaflets, and Medication Guides; (2) the FDA collaboratively develop, test, and implement a single-document CMI process based on rigorously defined, essential information needed by patients to safely and effectively use medications; (3) the FDA validate CMI prototypes in actual use studies; (4) CMI should be provided in electronic formats on a publicly accessible Web site so that

prescribers have access to these tools for improving patient adherence; and (5) CMI should stand on its own and not be an integral component of pharmacy marketing activities. (New HOD Policy)

3. That Policy H-115.995, Patient Instructional Leaflets (PIL), be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500

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18. 21 CFR 208, Subpart B – General Requirements for a Medication Guide, Section 208.20, Content and Format of a Medication Guide, December 1, 1998.

APPENDIX

H-120.967 Dispensing of Computer Generated Drug Information
1. Our AMA continues to cooperate with the National Council on Patient Information and Education (NCPIE), USP, the FDA and others to establish standards for patient information. 2. Our AMA continues to participate on the NCPIE to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE. 3. Our AMA will monitor the ongoing re-evaluation of how consumer medication information is designed and provided in the US and provide input to ensure that such documents are clinically useful, written at the appropriate literacy level, and promote patient adherence. (Res. 512, A-95; Appended: Sub. Res. 508, A-10)

H-115.981 FDA Mandated Patient Information Sheets
Our AMA supports making every effort to convince the FDA to discontinue mandatory patient information sheets in estrogen prescriptions in order to promote compliance in taking prescribed medication for the improvement of the health of patients. If the mandatory patient information sheets cannot be discontinued, the AMA supports making every effort to convince the FDA to change mandatory patient information sheets in estrogen prescriptions to present a more balanced evaluation of the benefits and risks. (Res. 218, A-91; Reaffirmed: Sunset Report, I-01)

H-115.995 Patient Instructional Leaflets (PIL)
(1) Our AMA advocates the following basic principles in any program for supplying drug information to patients: (a) Not all prescription drugs require PILs. Only special classes of agents need expanded patient information. (b) The PIL is not and should not be considered the basic vehicle for drug information to the patient; this is a function which must be retained by the prescribing physician. Instead, the PIL should be considered an educational adjunct to reinforce the physician's discussion and instruction to the patient. (c) PILs should not be mandatory for all patients. (d) The physician must have the prerogative to determine whether the PIL is in the patient's best interest. (e) PILs should present a fair balance of benefits and risks without undue emphasis on adverse effects that could be alarming to the patient. (f) The PIL should enumerate only selected, significant, documented side effects and adverse reactions. It should not contain a long list of possible, suspected, rare or undocumented side effects as is done in the pack-age insert for physicians. (g) PILs should be dispensed by the physician or by the pharmacist as directed by the physician. (h) PILs should not be developed unilaterally by the federal government but should represent a cooperative effort by the major organizations of medicine and pharmacy. (2) The impact of PILs on the quality of medical care should be evaluated in carefully controlled studies. (CSA Rep. B, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-05)