Examining Alternate Standardized Scripts to Improve Comprehensive Medication Review Participation Rate

A. Miguel[1], A. Hall[1], W. Liu[1], R. Segal[1], D. Koskinas[1], A. Ballew[2]
[1]University of Florida, [2]WellCare Health Plans, Inc.

Background

➤ Medicare Part D sponsors are required by Centers for Medicare and Medicaid Services (CMS) to offer a comprehensive medication review (CMR) to eligible beneficiaries through the sponsor's Medication Therapy Management Program (MTMP).

➤ Starting with the 2016 Star Ratings, Medicare Advantage Prescription Drug Plans (MAPD) and stand-alone Prescription Drug Plans (PDP) will be rated on a new measure that examines the percentage of MTMP eligible members that participate in a CMR.

➤ An earlier investigation compared two alternate live telephonic CMR recruitment scripts and found that by enhancing beneficiaries' understanding of a CMR service; beneficiaries were more likely to accept the offer of a CMR. However, there is still room for improvement as nearly half of the beneficiaries in the previous study still chose to decline the service.

➤ Based on results from the previous trial a new script was developed with scripted answers for a special frequently asked questions section to enable call agents to address patient concerns noted from the previous trial

Objective

To develop and evaluate the effects of modifying a CMR recruitment script in response to specific patient concerns and reasons for declining an offer for a CMR

Methods

CMR RECRUITMENT

➤ WellCare Health Plans, Inc. MAPD and PDP beneficiaries who are eligible for a CMR are identified by WellCare and automatically enrolled into WellCare's MTMP on a quarterly basis. Each MTMP enrollee is given the opportunity to accept an offer to participate in a telephonic CMR via telephonic CMR recruitment outreach utilizing standardized call scripts. CMR recruitment calls were made by a call vendor experienced in healthcare survey research and call center support services.

CMR RECRUITMENT PROCESS

MTMP Enrollment → CMR Recruitment via Phone → CMR Scheduled → CMR Provided to the Member

via Mail if cannot be reached by phone after 2 attempts

A CLOSER LOOK AT CMR RECRUITMENT AND PARTICIPATION

CMR Recruitment:
- Roll-over from the Previous Year Accepting CMR offer → CMR Scheduled → CMR Provided
- Declining CMR offer / Opt-out of MTMP / Unable to Reach
  - Missing Appointment / Declining CMR / Inactive Membership / Unable to Reach

STUDY DESIGN

The study is a randomized control trial evaluating the effects of a modified recruitment script (Script C) compared the original script (Script A) used in a previous investigation on increasing CMR acceptance beginning with the first quarter of MTMP enrollment for the plan year 2013.

Control Group (Script A) The control script equipped with features to enhance member response, such as a call back scheduling option. Script A first confirmed the person's membership status with the Part D plan, then proceeded with their enrollment status in the MTMP and offered the CMR service to the members who confirmed their desire to participate in the MTMP. Script A described the CMR service, but did not emphasize key benefits and barriers to CMR participation.

Intervention Group (Script C) Newly modified script designed to offer responses to common barriers to CMR acceptance. Script C incorporated both textual changes to provide members with more information and structural changes to maximize the number of members who were offered the CMR service. Key changes included:

➤ Introduction was modified to clearly state the purpose and anticipated length of the call.
➤ Key components of a CMR were explained sequentially to describe the CMR experience from start to finish.
➤ The sequence of the questions was carefully restructured to maximize the number of members who were offered the CMR.
➤ Rebuttals to common concerns and barriers to CMR acceptance were built into the script to help agents respond and ultimately help members overcome these barriers to CMR acceptance.
➤ To help the members process the information, a very succinct summary of the service was built into the script to recap the information presented.

Statistical Analysis
➤ Differences in baseline patient characteristics between the two groups were assessed using chi-square test for categorical variables and student t-test for continuous variables.
➤ Response rate was defined as the proportion of subjects who spoke with a call agent and agreed to participate in the CMR out of those who indicated themselves as current members of the Part D plan.
➤ A logistic regression model was built to evaluate variables associated with the member's decision to accept a CMR or not.
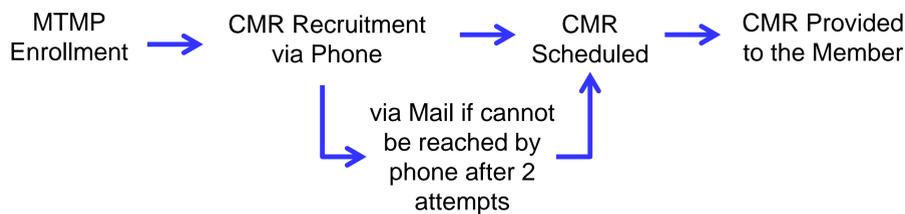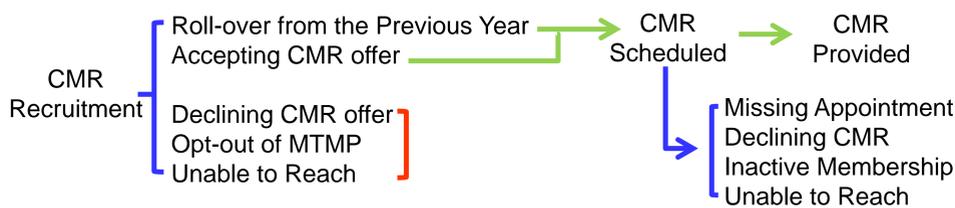
Results

Of the members randomized to receive Script A or C, 14.6 % and 12.9% were exposed to Script A or C respectively. Thirty-five percent of members recruited using Script C (N=5,822) compared to 30% of those recruited using script A (N=6,622) accepted the offer of a CMR (OR 1.07, 95% CI 1.00-1.15). In the Script C group, after hearing scripted responses to a presented barrier, 18% of members that initially declined ultimately accepted the CMR offer. Results of a multivariate logistic regression showed that other variables that predicted CMR acceptance included total chronic medication count, low income subsidy status, previous MTM program status, call day and time, respiratory disease comorbidity, and mental health disorders comorbidity.

Table 1: Member Demographics

Category		Script A	Script C
N		45,251	45,263
Gender (% Male)		36.8	37.1
Age (avg. yrs)		69.4	69.3
Low Income Subsidy (%)		98.3	98.3
Member Status	New Members	28.6%	28.6%
	Return Members Accepted	0.3%	0.3%
	Return Members Declined	7.4%	7%
	Return Members Received	0.05%	0.03%
	Return Members No-Response	47.3%	48.2%
	Return Members Status Unknown	16.3%	15.9%
Plan Type	PDP	84.4%	84.7%
	MAPD	15.6%	15.3%
Language	English	80.7%	81.1%
	Spanish	4.3%	4.1%
	Unknown	15%	14.8%
Total Disease Count		6.6	6.6
Total Chronic Medication Count		10.8	10.8
Day of the Week Call Was Made	Monday-Friday	93.3%	96.3%
	Saturday-Sunday	6.7%	3.7%
Call Attempt Time	(Morning vs Afternoon)	82%	82.4%
Note: All p-values for member demographics > 0.05.			

Table 2: CMR Acceptance Rate

Script Element Exposure	Script A	Script C
% CMR Enrollment Rate	1981/6622=29.9%	2052/5822=35%
% Enrollment rate not exposed to rebuttals	N/A	1896/4937=38.4%
% Enrollees that changed CMR acceptance decision after exposure to rebuttal regarding already having a doctor or pharmacist	N/A	131/760=17.2%
% Enrollees that changed CMR acceptance decision after exposure to rebuttal regarding being on medications for so long CMR not needed	N/A	25/121=20.7%
% Enrollees that changed CMR acceptance decision after exposure to rebuttal regarding confidentiality of their health information	N/A	0/4=0%
% Enrollees that changed CMR acceptance decision after exposure to any rebuttal	N/A	156/885=17.6%

Table 3: Adjusted Odds Ratio for Predictors of CMR Offer Acceptance

Variables	Adjusted Odds Ratio (95% CI)
Script C	1.07 (1.00-1.15)
Age (years)	0.99 (0.99-0.99)
Female	1.07 (0.99-1.15)
Total Disease Count	1.01 (0.99-1.03)
Total Chronic Medication Count	1.02 (1.01-1.04)
Low Income Subsidy	0.70 (0.55-0.87)
MTMP Member Status	
New members accepted (vs return members)	0.39 (0.28-0.55)
Returned members declined (vs. return accepted)	0.53 (0.37-0.77)
Returned members no-response (vs. return accepted)	0.21 (0.15-0.30)
Return members received (vs. return accepted)	1.08 (0.35-3.28)
Call attempt M-F vs. weekend	0.69 (0.61-0.78)
Call attempt AM vs. PM	0.76 (0.70-0.84)
Congestive heart failure comorbidity	0.95 (0.84-1.08)
Hypertension comorbidity	1.09 (0.98-1.22)
Diabetes comorbidity	1.07 (0.98-1.16)
End stage renal disease comorbidity	1.09 (0.99-1.19)
Alzheimer comorbidity	0.47 (0.38-0.60)
Respiratory diseases comorbidity	1.20 (1.11-1.30)
Bone diseases comorbidity	0.97 (0.89-1.07)
Mental health disorders comorbidity	0.90 (0.83-0.98)

Conclusion

Modification to a script used to recruit MTM eligible MAPD and PDP beneficiaries to participate in a CMR outperformed a previously tested script. The new script which provided responses to common barriers presented by beneficiaries to accepting a CMR was effective in converting members that initially declined a CMR to accept. Findings also suggest that further efforts will be required in order to engage member that do not respond to telephonic outreach for recruitment.