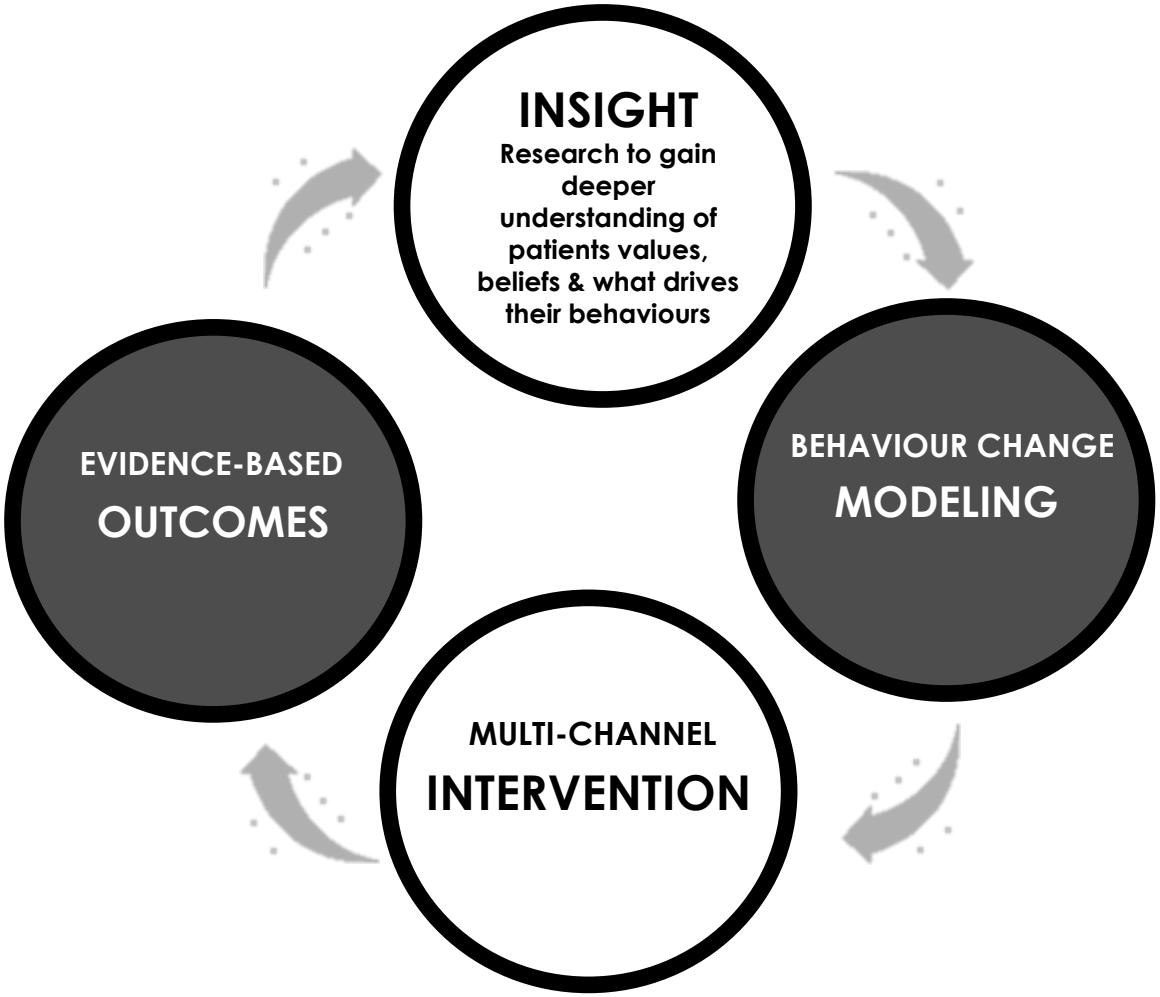
Co-designing a Social Marketing Solution to Medicines Adherence

changemakers

This isn't just about patient marketing; its about a deeper understanding, interaction and engagement with people. It's about, a new level of relationship that will …

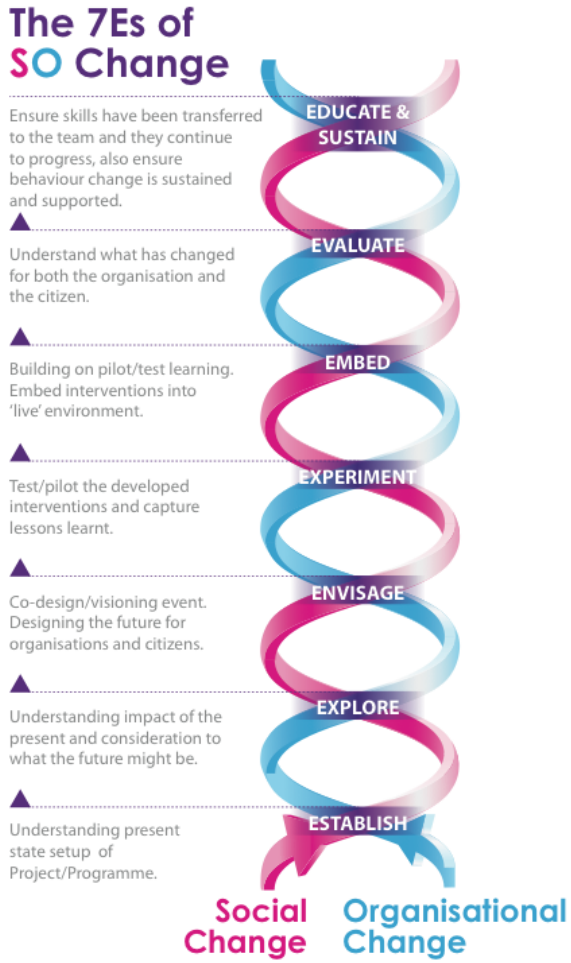
- Facilitate people to make positive, holistic behaviour-based changes
- Sustain those changes long term
- Nurture positive changes to behaviours and from deep insight of ethos and values
- Impact the interaction between individuals and their wider environment.

OUR OFFERING



SO Change Methodology

- To drive sustained behavioural outcomes, we work at both the Social (patient) and Organisational level, using 7E's Model
- It combines behavioural change and organisational change theories
- It places the patient and the organisations at the centre of the process – creating a new DNA of change
- It builds on
  - foundation of insight and evidence
  - It is focused on co-creation
  - Involves all interested parties in the process of intervention design.



THE VALUE/COST EXCHANGE MATRIX

As we design interventions we use additional tools such as the Value/Cost Matrix. This has its foundations in behavioural ecomonics and is used to help determine the response to the behavioural interventions.

Active Decision Conscious / Considered

Hug

Financial reward for not smoking
Positive health messages, eg '5 a day'
Subsidy for insulating home
Recycling lottery prize
Free pedometer, low energy light bulb etc.
Financial supplement for saving

Smack

Penalty fine for littering
Speed reduction cameras general
Alchohol price increase
Factual health warning campaign
Access or privilege restrictions for repeat offenders

Incentive
Reward

Disincentive
Punish

Nudge

Deposit on bottle recycling
Only low energy light bulbs available for purchase
Saving default scheme
Opt-out schemes for organ donation
Positive emotional health campaign

Shove

Sleeping policeman speed bump
Minimal alcohol unit price
Alarms
Smoke free zones
Emotional health warning campaign

Passive Decision Automatic / Unconcious

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BEHAVIOURAL CHANGE

Meds Adherence

DOING MORE OF THE SAME IS INSANITY!

"It would be easy to give the public information and hope they change behaviour, but we know that doesn't work very satisfactorily…Otherwise none of us would be ***obese***, none of us would ***smoke*** and none of us would ***drive like lunatics***"

Iain Potter
Director New Zealand Health Sponsorship Council, New Zealand Herald

"COSTS OF COPD…"

- COPD is the **third leading cause of death** in the U.S.
- Progressive disease – yet it's **preventable and treatable**
- **Greatest determinant of disease progression is smoking** – yet many patients continue to smoke
- In 2010, the cost to the nation for **COPD was projected to be approximately $49.9 billion**, $29.5 billion in direct health care expenditures, $8.0 billion in indirect morbidity costs and $12.4 billion in indirect mortality costs.

"COSTS OF COPD…"

So why aren't we making greater progress in terms of disease management and prevention?

Historically Managing COPD?

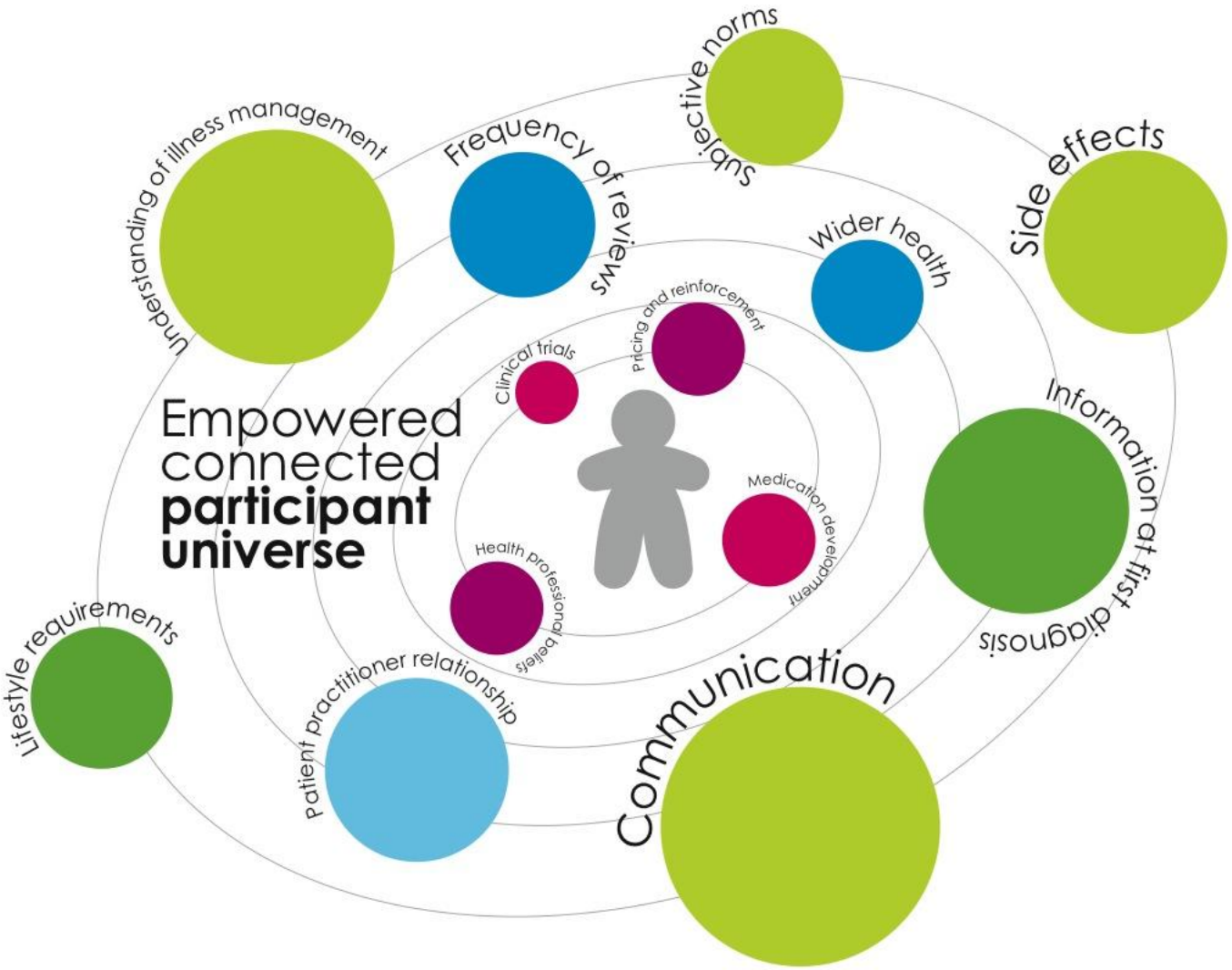
Effective medications are the foundation to good disease management…

…However, if we are truly looking to support a patient, we must move beyond the medication and provide a more holistic 'patient centered' approach.

… As we do this we must explore and understand the complex factors that impact patient lives.

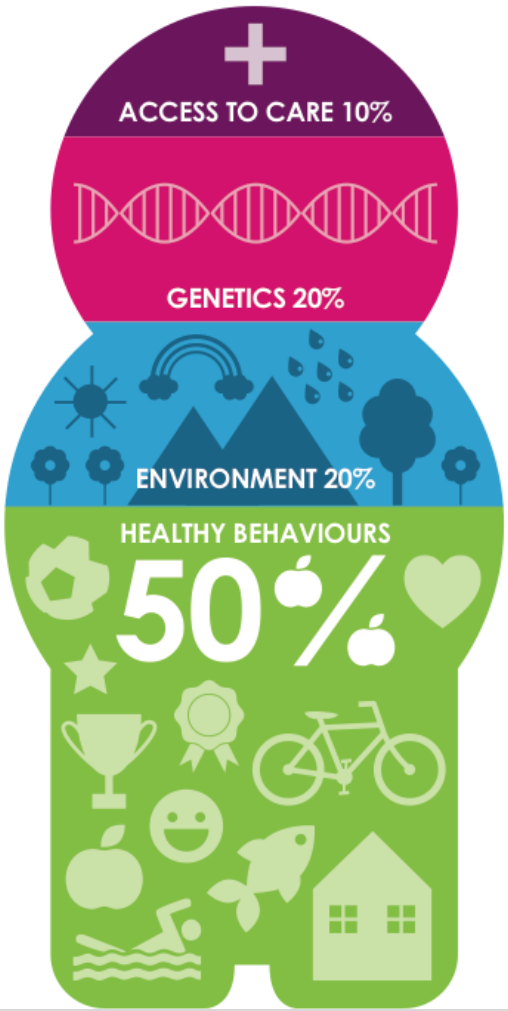
…We must understand the patient universe.

UNDERSTANDING THE PATIENT UNIVERSE



WHERE DO WE START WITH COPD?

PATIENT CENTRED MODEL



Places the patient at the very heart of our work.
Treats them as the **individual**s they are…

- Moves away from one size fits all
- Based on deep patient insight
- Ensures interventions are co-created with patients and HCPs
- Engages using multi-modal approach
- Focuses on wider health and wellbeing
- Designed to deliver **evidenced health outcomes.**

SHIFT IN MINDSET?

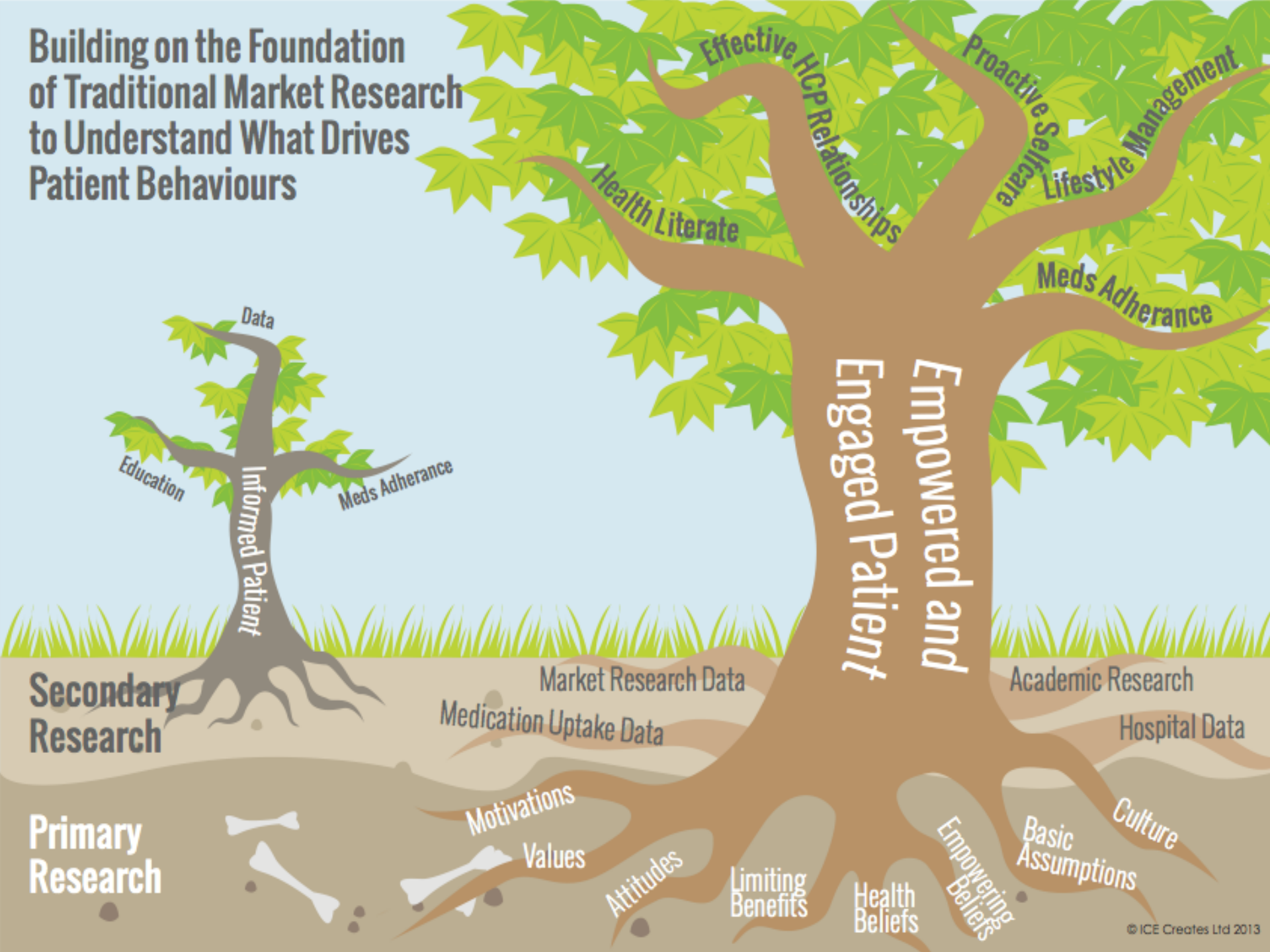
By changing our mindset from…

"What's up with these people that they don't understand"

to…

*"What's up with **us** that we don't understand these people"*

The start of effective communication should be
a deep understanding of human behaviour and how to change it.


Building on the Foundation of Traditional Market Research to Understand What Drives Patient Behaviours
Effective HCP Relationships
Proactive Selfcare
Lifestyle Management
Health Literate
Meds Adherance
Empowered and Engaged Patient
Data
Education
Informed Patient
Meds Adherance
Secondary Research
Market Research Data
Medication Uptake Data
Academic Research
Hospital Data
Primary Research
Motivations
Values
Attitudes
Limiting Benefits
Health Beliefs
Empowering Beliefs
Basic Assumptions
Culture
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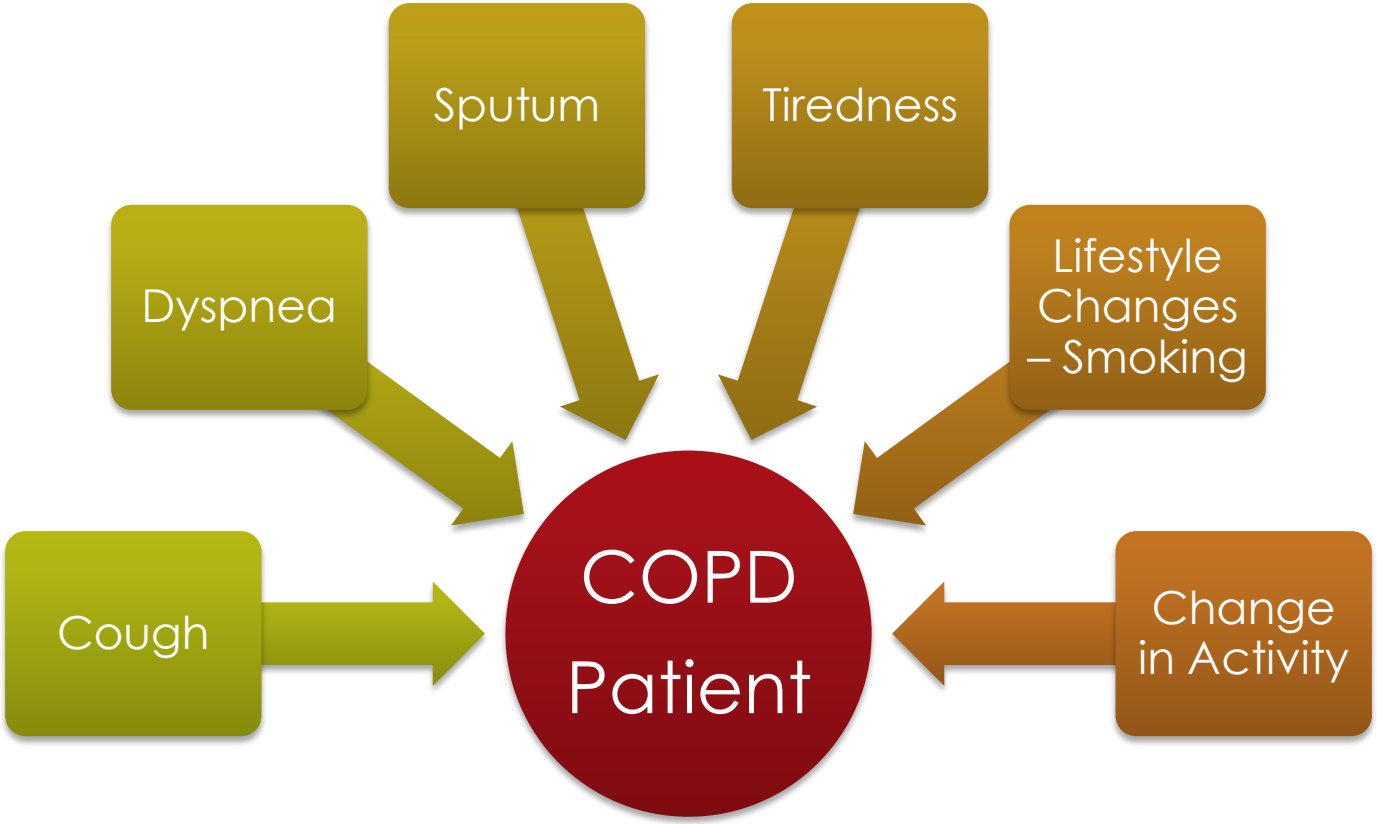
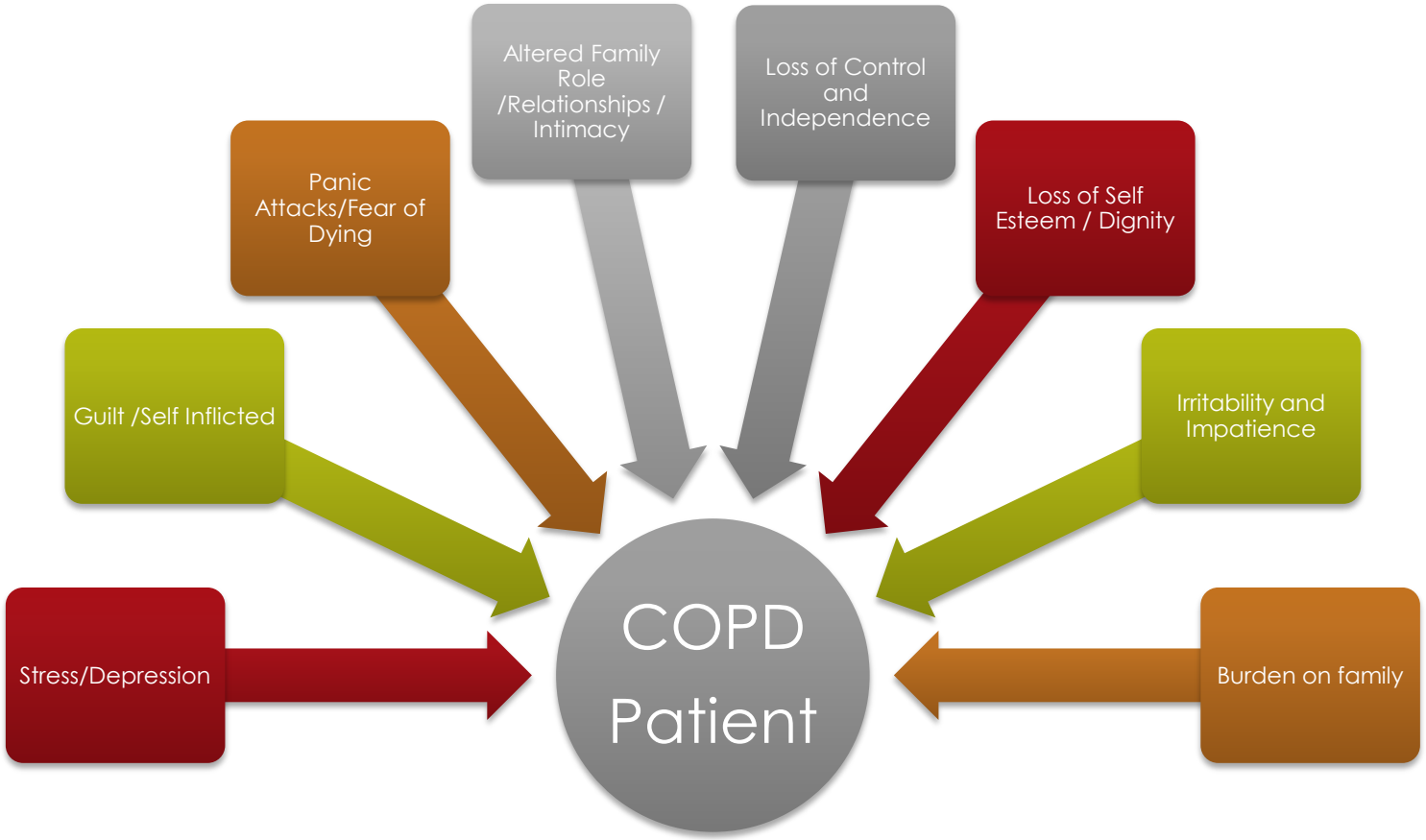
WHAT DO WE KNOW ALREADY?

Immediate Medical Implications

Lots of Existing Research on Impact of:



WHAT ELSE DO WE NEED TO CONSIDER?



WE HAVE TO HELP PATIENTS MANAGE FACTORS SUCH AS …

COPD sufferers are statistically shown to retire earlier due to a belief that they are too ill to work

80% of COPD sufferers report being unable to maintain same lifestyle

50% or more decrease the amount they go out and visit friends

One in five felt a burden to their family

Two thirds of sufferers still continue to smoke after being diagnosed

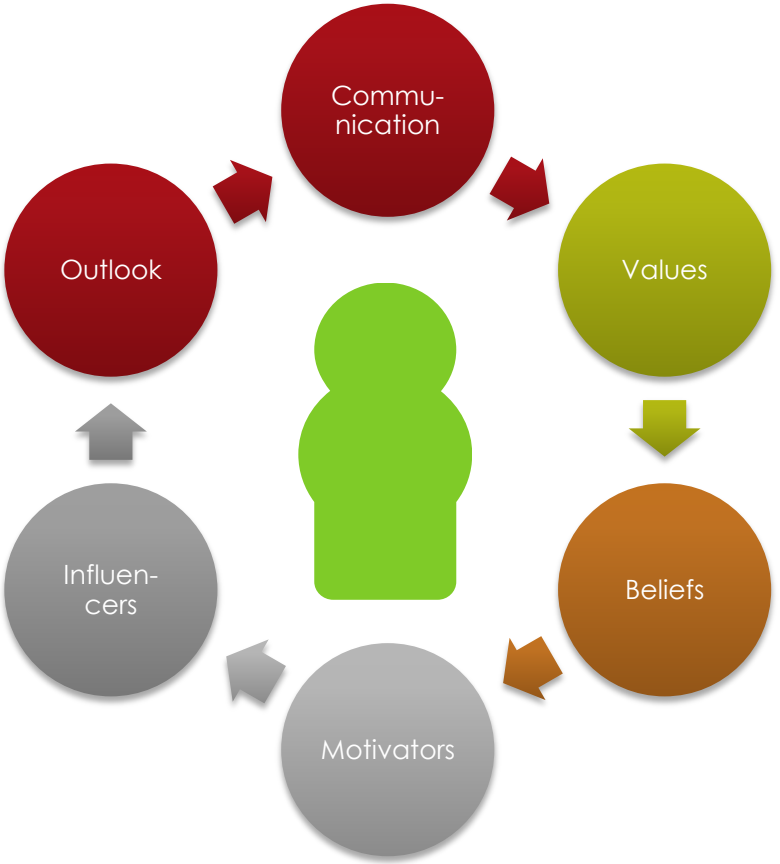
41% unable to plan for their future

PUTTING IT TOGETHER

We will help patients manage what they perceive as the negative aspects of COPD, and to create interventions that have a **positive impact on the 'whole life'.**

CREATING PATIENT ARCHETYPES

- Working with primary and secondary data sets, we design patient 'archetypes'
- We group patient types according to shared factors
- Moves away from 'one size fits all' to tailored and targeted bespoke programmes of intervention for each archetype group



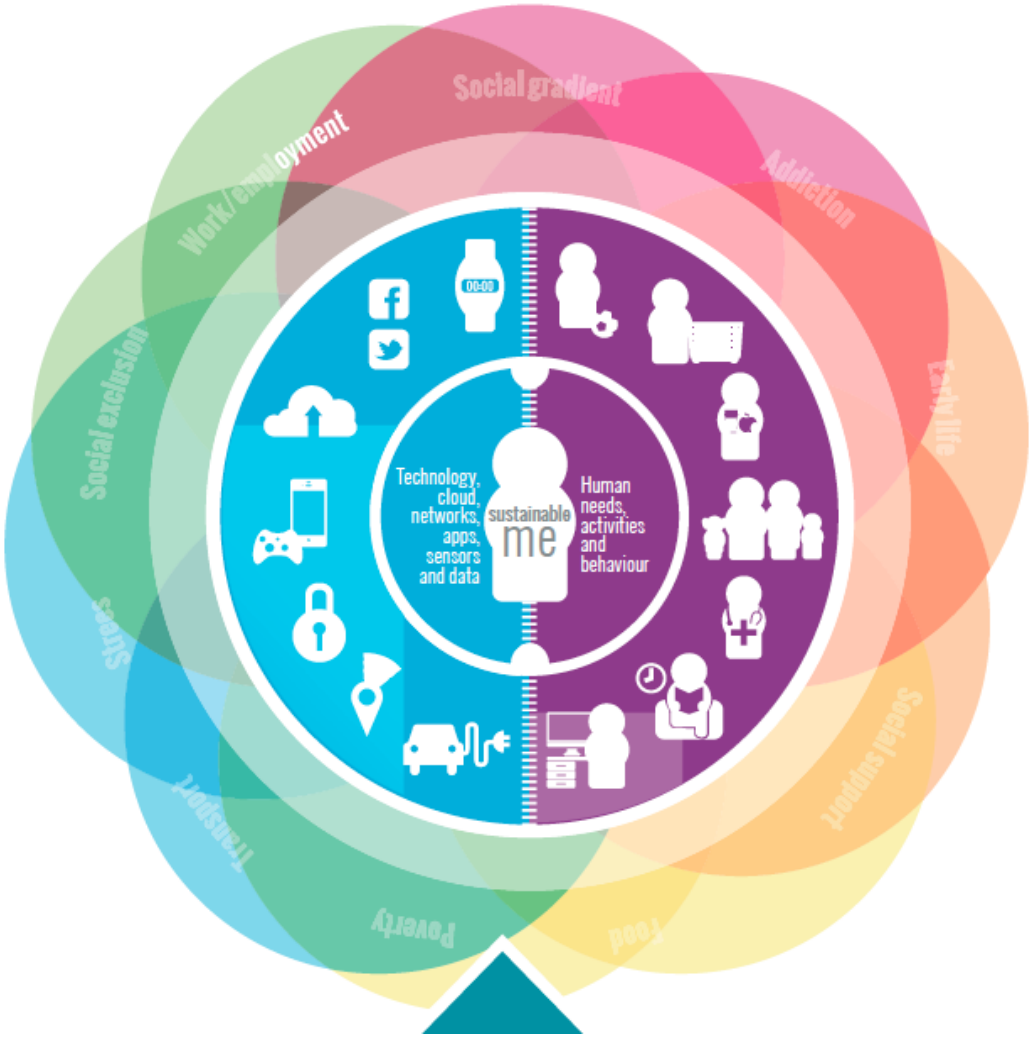
SAMPLE A'TYPE – FEARFUL FIONA

- Diagnosed aged 45 – been smoker since 16, despite being a serial quitter
- Fearful of what disease will bring – has panic attacks and feels isolated. Doesn't talk to her family but needs support
- Fiona's life has changed considerably – she is less active, she's worried about becoming breathless and has gained 24lbs
- In herself, Fiona is well. Due to her fear, she manages her meds religiously
- Fiona has had a number of hospital stays due to anxiety induced exacerbations. She is also a frequent visitor to her doctor – so is unnecessarily costly.

SAMPLE A'TYPE – PRAGMATIC PETER

- Diagnosed aged 45 – been heavy smoker since 21, quit as soon as diagnosed
- Understands his condition and how to minimize exacerbations – he is in control of his symptoms but find managing meds with his shift pattern a bit problematic
- Peter has taken on new hobbies, he used to run but had to stop and so got a dog and now walks. He is finding that he is getting more breathless walking long distances now - his doctor suggests losing weight may help
- Peter is very pragmatic in terms of his condition. He talks openly of what could happen and makes the most of every day. This is good for Peter but difficult for his family who need some support to understand career progression
- Peter doesn't see his doctor unless he really needs to. He'd like to be able to manage more of his health information online and already tracks his lung function daily at home and keeps a diary.

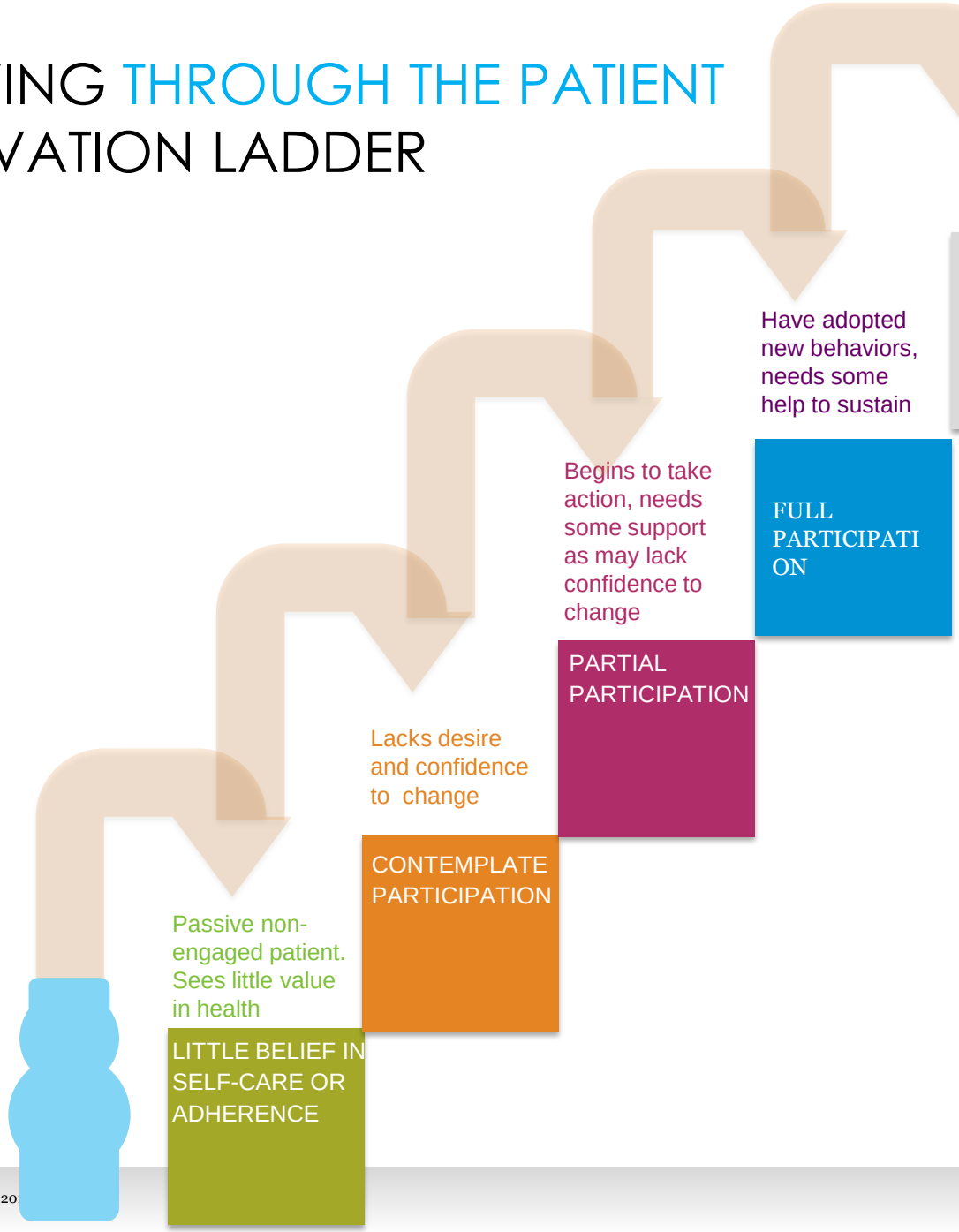
Empowered Connected Paitent



INTERVENTION MIX

These have to be guided by insight and importantly, by patients, but we suggest the following:

MOVING THROUGH THE PATIENT ACTIVATION LADDER

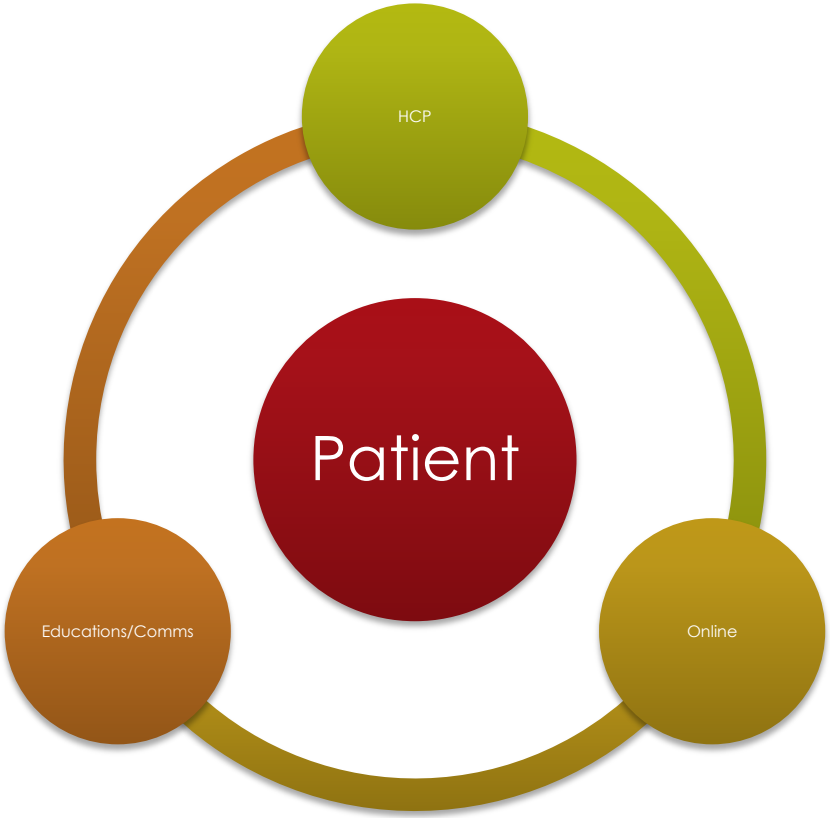


Important to Note:

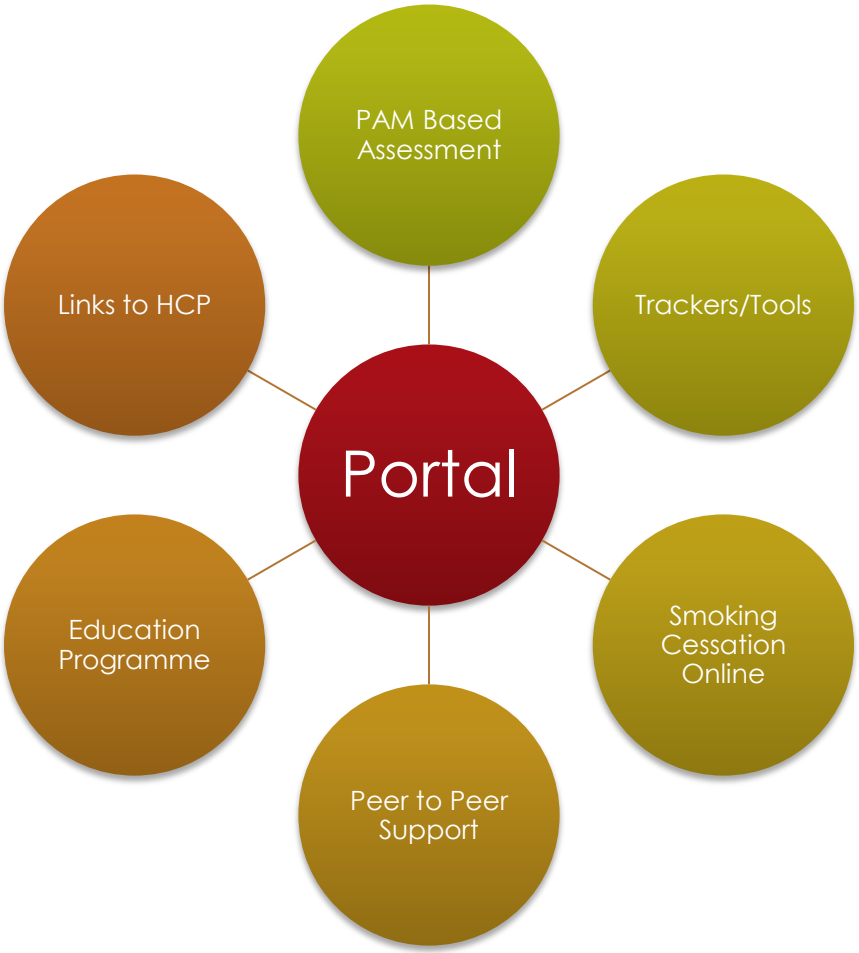
- Patients can enter the ladder at various stages
- Patients at greatest risk and with poor self-care receive most support
- Their journeys will differ – as will their progress
- Not every patient will get to liberated self -care, however, it is important that they are supported to progress
- Interventions must support patients at all stages
- To support patients through the ladder, a combined on-off line approach will be required.

ONLINE – OFFLINE – PERSONAL

We will create a multi-modal interventions and will create interventions that enable patients to move through the stages of engagement and activation:



ONLINE MULTI PLATFORM PORTAL



ONLINE TRACKERS

Working with the HCP, patients will agree the factors that they will use to track exacerbations against such as:

- Lung function – home testing and recording
- Personal wellness and positivity ratings
- Anxiety / panic levels
- Meds adherence
- Diet
- Exercise
- Smoking levels
- No. of exacerbations.

The tool provides the ability to understand the wider factors that are triggering exacerbations.

This tool will also be important for supporting patients when they return home from hospital after an exacerbation.

Tracking information can be shared electronically with the HCP.

ONLINE TOOLS

The portal will offer patients a range of online tools including:

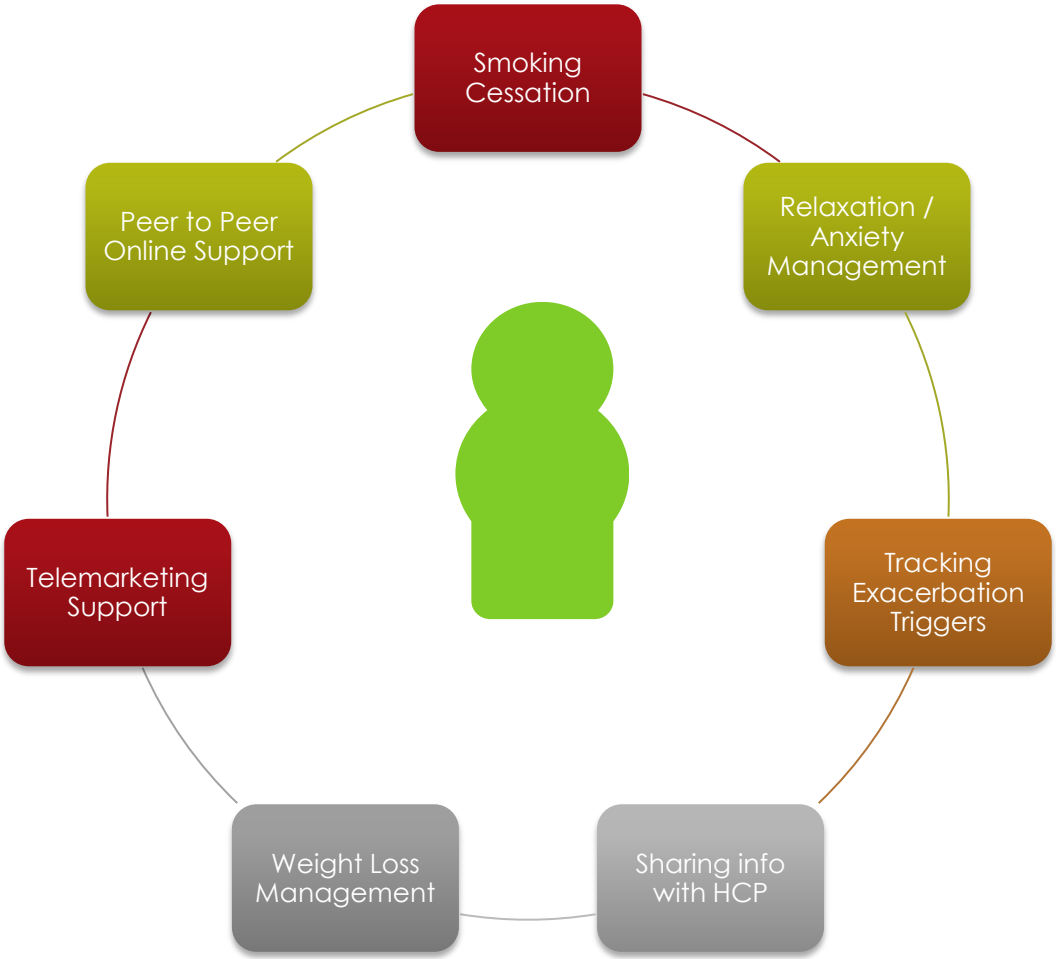
- Online smoking cessation
- Relaxation – managing anxiety and panic attacks
- Adherence reminders
- Diaries for appointments
- Peer to peer support functions
- Education and trusted third party links
- Educational resources
- Ability to link and share information with the HCP
- Member Consultations (as in HCP and Patient)
- Family education and signposting to help
- Provides motivational messages etc.
- Data mining and reporting – NON-PATIENT.

OFFLINE / PERSONAL

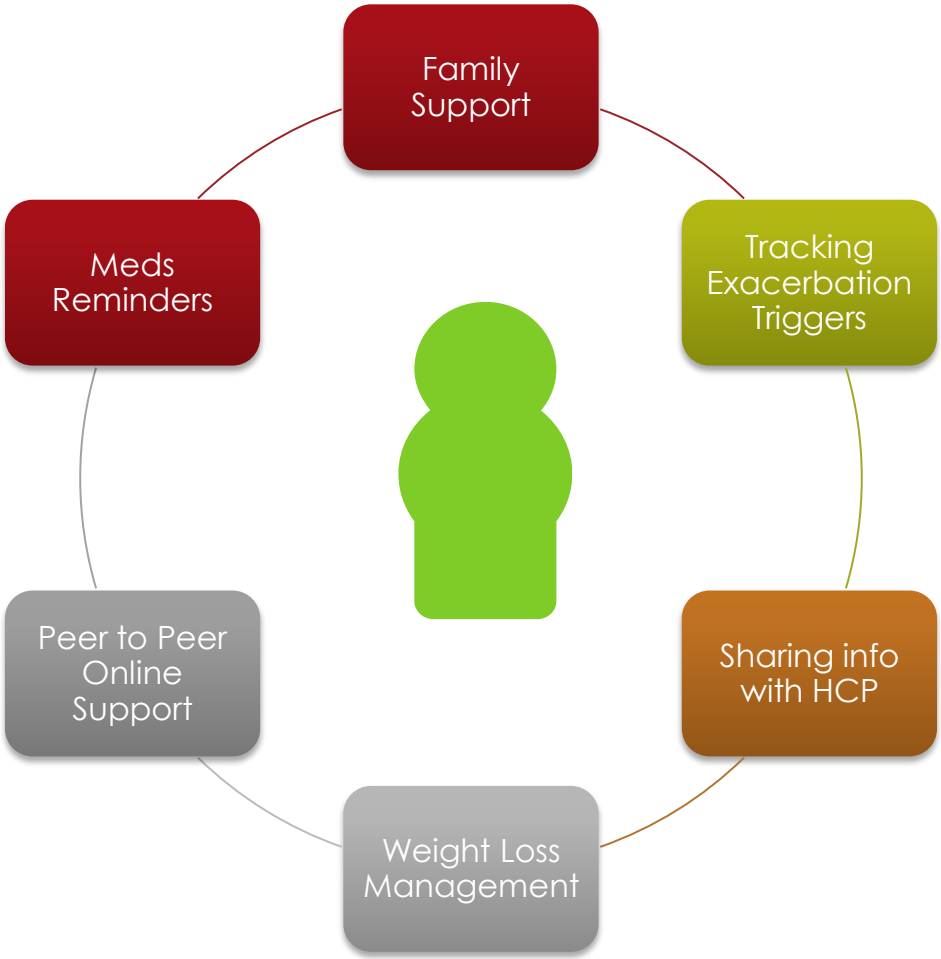
This is a core element of the delivery and should include:

- HCP support – engaging in directing patients to the portal
- Agree and set goals with patients
- Monitor goals with patients
- Initial support – encouraging archetypes such as ‘Fearful Fiona’ to embrace support such as relaxation
- Actual service provision e.g. smoking cessation
- Telemarketing support at key exacerbation points.

Interventions for Fearful Fiona



Interventions for Pragmatic Peter



WHAT ARE THE OUTCOMES FOR YOU?

- Evidenced patient outcomes and associated costs savings in terms of:
  - Condition management
  - Adherence
  - Reduction in exacerbations and hospital admissions
  - Lifestyle related behavior change impact – smoking, weight, physical activity

- Ability to track patients post exacerbation episode / hospitalisation and share data with HCP

- Ability to track and evidence changes in health belief as a result of the intervention

WHAT ARE THE OUTCOMES FOR YOU?

- Evidence support for patients to take responsibility for their own health to set, report and share their progress against patient centered goals
- Evidence the impact of combined online/offline programmes, to improve both patient and their family's ability to positively manage COPD and generate positive increase in patients reported quality of life
- Reported and tracked increase in patients' wellbeing and confidence in ability to not only manage their condition but to sustain/improve their quality of life
- Ability to cross map behaviour, lifestyles and psychological state in relation to exacerbations and understand how psychological factors are impacting condition . This data will be the basis of archetype and programme refinement
- Evidence of patients being up-skilled to manage mental health and panic attacks.

NEXT STEPS?

APPENDIX

COPD – From Insight to Outcome

Issue Faced: Poor early diagnosis rates, lack of self management, poor adherence in terms of drugs and contributing life style factors.

COPD – From Insight to Outcome

Insight Revealed: Insight was conducted with patients with varying level of condition severity (undiagnosed smokers, mild, moderate, severe, end of life). It was apparent that patients in mild, moderate and severe groups felt isolated and vulnerable, not understanding their condition and the impact that good adherence and lifestyle management could have. In some cohorts there was a fatalistic view that COPD would kill them, which led to a lack of value of life, others felt ashamed that they had brought the condition on themselves and there was an overall high level of apathy that anything could be done to manage the condition once it was detected. This resulted in low detection rates, as 'it is better not to know, than to know you have a ticking time bomb that will kill you in the end".

COPD – From Insight to Outcome

End of life patients focused on their desire to "turn the clocks back", wishing they had done things differently and wanted to warn others what life was like if you ignored COPD. They felt a burden to their families and talked about how debilitating the condition has been, far more so than they had imagined.

Interventions – Non-Diagnosed

From the insight, the following interventions where designed:

To improve diagnosis rates:

- **Telesales targeted screening** – using segmented data, potential sufferers were contacted. As part of the the call they were taken through a screening based tool and if required were provided with additional information and referred to their HCP.
- **Community events** – it was evident that people did not know or understand the term COPD and as a result, we took COPD to them via a range of community road shows and events and supported with a radio based campaign. At the events people had the opportunity to speak with HCP, take part in initial screening and register for referrals or for follow-up contact calls for family.
- Stakeholder Engagement
- Direct Marketing – this was targeted to areas in which the segmented targeted groups lived in.

Interventions - Diagnosed

From the insight, the following interventions where designed:

To improve diagnosis rates:

- Breathe Easy Group – Range of groups were created for COPD sufferers and their families to get together and to support each other. Peer mentoring was a key component of these groups. The groups focused on education, support and mental wellness. They were designed to help sufferers to understand that COPD is manageable
- Tele-health – Sufferers who traditionally struggled to managed their condition where called at defined times e.g. start of the winter to remind them of the importance of condition management and how to prevent and manage exacerbation that cold lead to hospitalisation
- Smoking Cessation Service – Aimed specifically at supporting smokers with COPD, to reduce and quit smoking
- Stakeholder Engagement and PR Campaign to promote the benefits of condition management on quality of life.

COPD Outcomes

Evidenced outcomes included:

- Project Awarded British Lung Foundation Excellence Award
- 80% targeted referral rate into further support after initial screening of segmented 'undiagnosed' cohort
- 4.25% increase of 'additional self referrals' at HCP for COPD screening
- 905 referrals smoking cessation support
- Breathe Easy Groups run by COPD sufferers – established and running regular sessions for both COPD sufferers but also for families/carers
- Decrease in hospital admission rates, although these cannot be solely attributed to the Project.