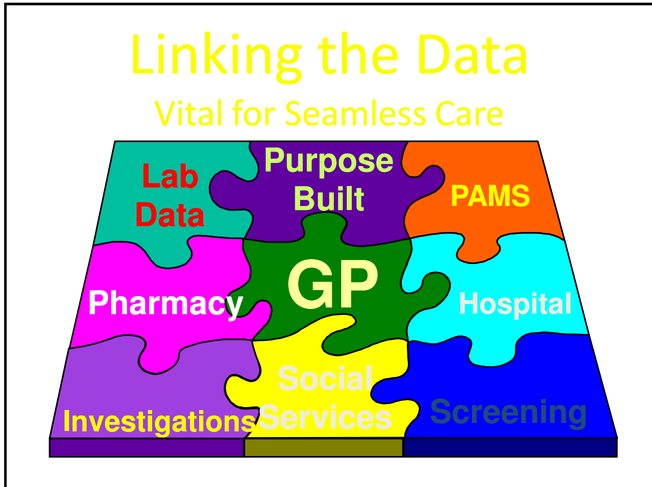
Improving Compliance

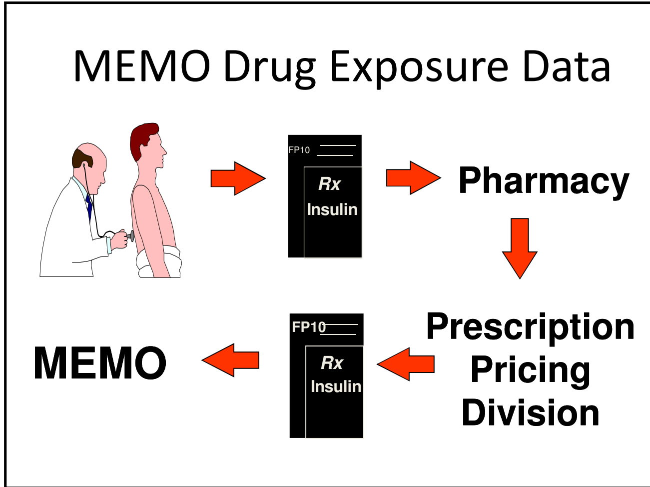
3rd International Diabetes Conference
16 Feb 2013
Charles Fox
(Thanks to Bob Anderson)

Linking the Data

Vital for Seamless Care



MEMO Drug Exposure Data



Risk reduction in diabetes

- **Oral hypoglycaemics**
- **Statins**
- **Aspirin**
- **Beta blockers**
- **ACE inhibitors**
- **Antihypertensives**

Concordance with therapy

- **All patients with type 2 diabetes**
- **Jan '93 - December '95**
- **Prescribing history > 12 months**
- **No change in OHA class during study**

Outcomes

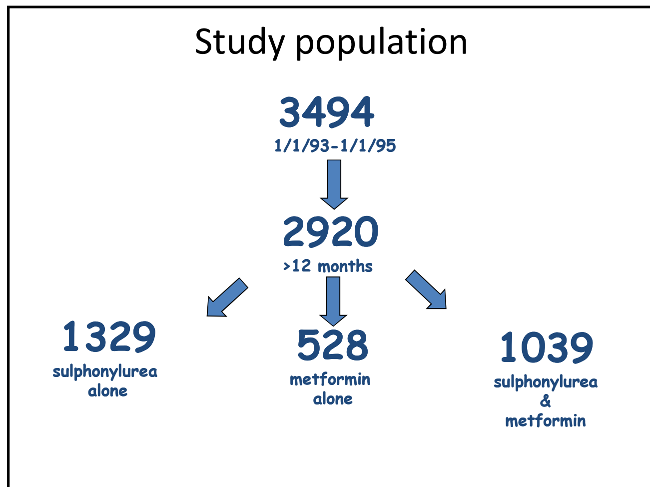
- **Adherence index:**

$$\frac{\text{total drug obtained}}{\text{total drug prescribed}}$$

days drug coverage per annum

- **Social class, co-medications, duration of diabetes**

Study population



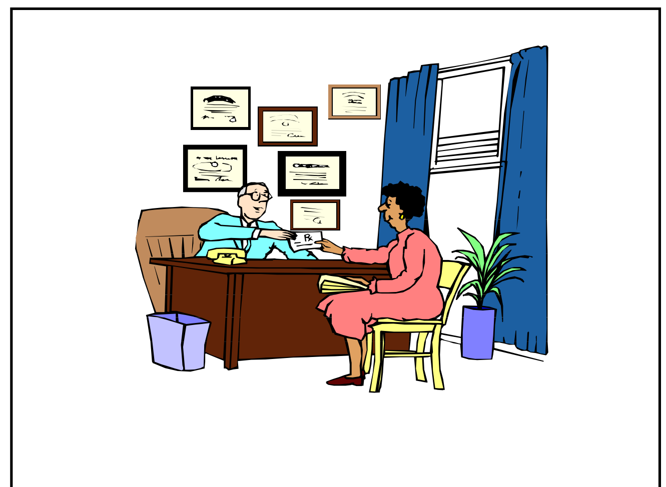
Adherence index by type of therapy

		>90%	<90%
Sulphonylurea	Monotherapy	32%	68%
	Polytherapy	19%	81%
Metformin	Monotherapy	34%	66%
	Polytherapy	13%	87%

Conclusions

- **Adherence low in monotherapy 31%**
- **Adherence worse in polytherapy**
  19% sulphonylurea 13% metformin
- **Single daily dosing advantageous**
- **Social class, multiple therapies, duration of diabetes associated**

"Diabetes fatigue"
It's not as easy as we think!!



…. "I hope these are easier to flush away than the last lot" ….

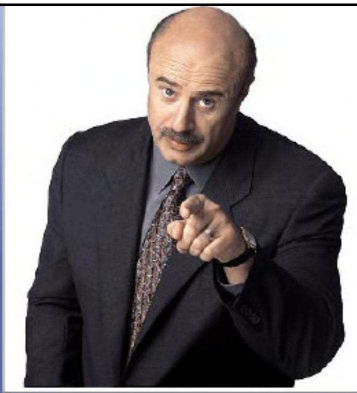
Your thoughts about the DARTS findings

Your thoughts about the DARTS findings

- Would they be different in 2013?
- UPKDS leads to polypharmacy

The clinicians dilemma: feeling responsible, but not in control…

Not In Control = Not Responsible.



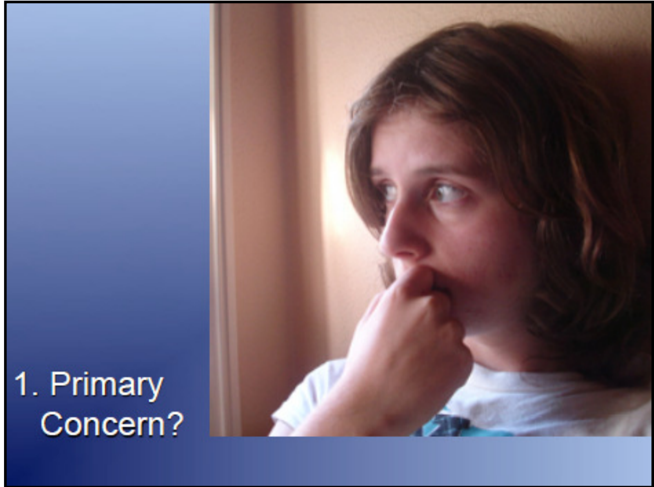
Feeling responsible but not in control → Persuasion

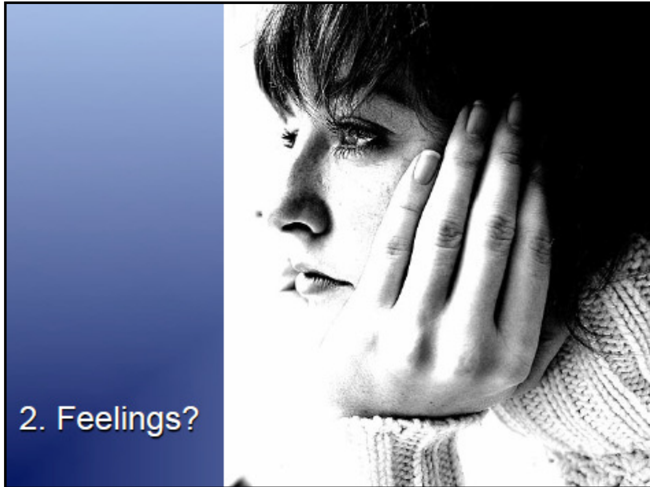
Resistance

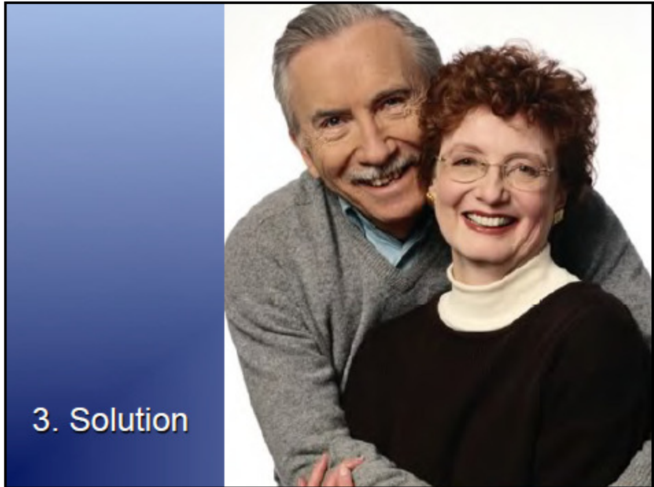
Noncompliance

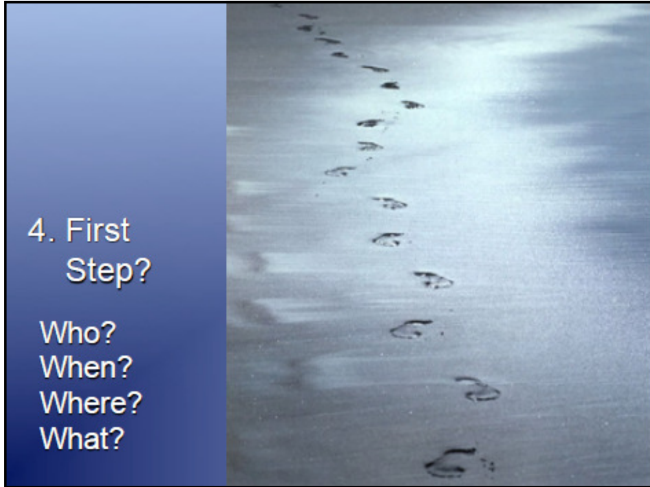
Frustrated & Resentful

Rule Followers









So how do we improve compliance?

- Listen to patients
  - Main concern
  - Their feelings
  - Their solution
  - How do they get there?
- WORK WITH PATIENTS