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Managing Medication Priority For Sponsors

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Managing Medications Priority For Sponsors

From the left, Michael Roszak, Chief Operating Officer at Express Scripts Canada; Chrissy Piraino, Director of Business Development for the Health Solutions Group at Shoppers Drug Mart; and Dr. Abhimanyu Sud, WorldCare Guest Speaker, Director of Safer Opioid Prescribing, and Assistant Professor at the Faculty of Medicine at the University of Toronto, discussed how chronic disease, the opioid crisis, and medication non-adherence are having an impact on employers at Benefits and Pensions Monitor Meetings & Events' 'Benefits 2019' session.

Chronic disease, the opioid crisis, and medication non-adherence are all having an impact on employer-sponsored drug plans.

For the most part, they drive up drug costs and are due, in part, to a healthcare system which is pharmaceutical based.

At *Benefits and Pensions Monitor's* 'Benefits 2019,' Chrissy Piraino, Director of Business Development, for the Health Solutions Group at Shoppers Drug Mart; Dr. Abhimanyu Sud, WorldCare Guest Speaker, Director of Safer Opioid Prescribing and Assistant Professor at the Faculty of Medicine at the University of Toronto; and Michael Roszak Chief Operating Officer, at Express Scripts Canada; shared their expert views on these problems, their causes, and potential solutions.

Statistics show the need for disease specific solutions is growing, said Chrissy Piraino, Director of Business Development for the Health Solutions Group at Shoppers Drug Mart. In 2007, 37 per cent of Canadians struggled with a chronic disease. Today this has risen to 54 per cent. It's an issue "that is not going away and it's actually getting worse." There are a number of factors that contribute to this with some harder to quantify than others which leads to the difference in employer perceptions of what the issue is.

Chronic diseases include cardiovascular diseases, respiratory ailments, chronic pain, mental health, obesity, diabetes, and so on. The factors behind the rise in chronic disease start with lifestyle choices. "Everybody has challenging schedules to manage, but do we all make the best choices all the time? Probably not," she said.

The statistics around some of these diseases are pretty sobering and shocking. The percentage of Canadian adults that are diabetic, or pre-diabetic, is 31 per cent; 50 per cent of Canadians will experience a mental illness by the age of 40; and the percentage of Canadians who are overweight or considered obese is 64 per cent.

Potential Impacts

The potential impacts on employers are increased drug costs, pressure on disability costs, and increasing pressure on premiums that employers are paying for their benefit plans. There is also a reduction of productivity which is harder to quantify. Yet, considerations of the impact on an employer's bottom line often take precedence over the members who are actually struggling with chronic disease, she said.

Part of the challenge is a gap in the Canadian healthcare marketplace. While

wonderful, it is "set up to be reactive – you get sick, you go to the doctor, you get a script, and off you go. You get about seven minutes with your GP to talk about one issue. Anybody suffering with a chronic disease is probably suffering from more than one issue. They also need day-to-day monitoring and support to help them on their journey to better health and they're not getting it." Patients with a chronic disease spend less than one per cent of their lives interacting with their healthcare provider about it, but "they're spending 100 per cent of their time trying to manage their illness, so there's a huge disconnect there," she said.

The keys to chronic disease management are patient empowerment, engage-

ment, educating people about their disease and how they can manage it and live productively. This includes lifestyle changes like picking the apple over the chocolate covered granola bar; taking medications properly; and, finally, getting proper follow-up and support from healthcare providers.

These solutions are available in "two buckets" – health coaching, day-to-day support programs using practitioners who provide support to members who need it most, and pharmacogenetic testing, – identifying the right medication for each individual.

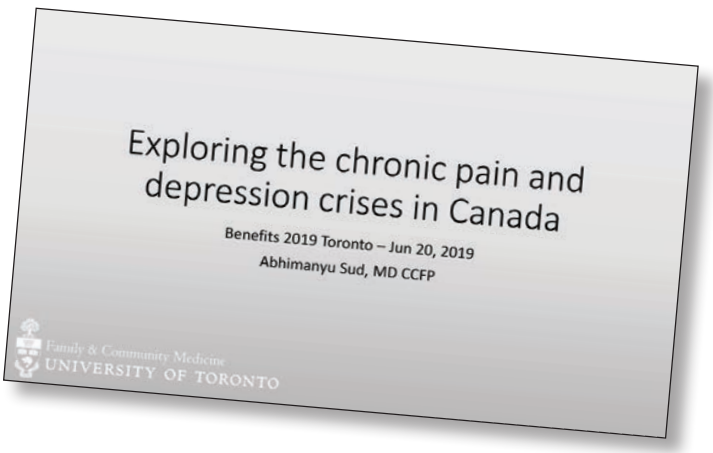
Pharmacogenetic testing is an evolving science, said Piraino. It is genetic testing to evaluate an individual's ability to metabolize different drugs and whether or not they will get a positive impact from them. It is now showing up in benefits plans as part of disability management programs and the major carriers do make it an option in dealing with mental health claims. The idea behind the science is that it can optimize drug therapy outcomes and reduce the cycle time that comes with just trying different meds.

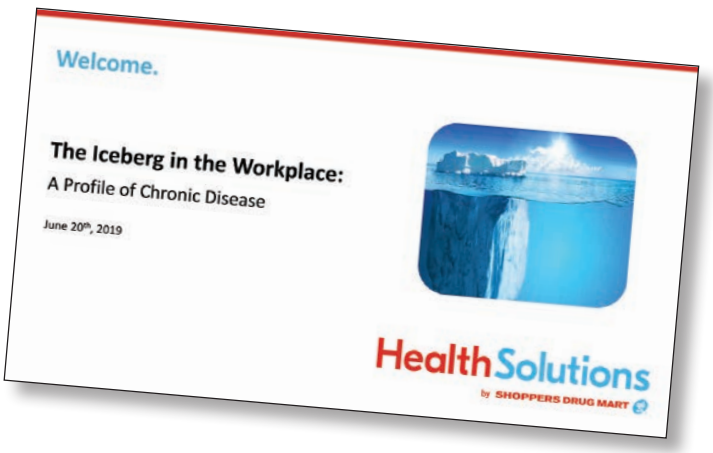
Health Coaching

The other pieces – patient empowerment, lifestyle changes, adherence to medication, and proper follow-up and support – fall under the health coaching solution. This can include care from a registered nurse, guidance from a pharmacist on the therapies that are being taken, and direction from a dietitian to help support an entire plan to promote positive lifestyle change.

By offering health coaching, plan sponsors are creating accountability for the member to stay on a plan and keep on it. At Shoppers', for example, the coaching program starts with a profile that is set up virtually with a case co-ordinator who works with the care practitioners. The care practitioners set goals, monitor progress, set those milestones, and stay with the person on their journey. Success is measured in small increments. This is because if someone can make, for example, even a one per cent positive impact to their A1C test for diabetes, these positive outcomes are just like dominoes and they are felt everywhere. Still, coaching programs only help if an individual sets achievable and realistic goals.

Chronic disease is really "today's iceberg in the workplace," she said. Plan numbers are not getting better, they're getting worse, but there is an opportunity right now to provide solutions to help people on the journey to better health.





About 20 per cent of Canadian adults live with chronic pain. Of those, 60 per cent also live with mental illness, typically either depression or anxiety, said Dr. Abhimanyu Sud, Director of Safer Opioid Prescribing and Assistant Professor at the Faculty of Medicine at the University of Toronto who spoke on the invitation of WorldCare.

People living with chronic pain and mental illness use healthcare resources at a higher rate, are prescribed higher doses of opioids, and are more likely to overdose on opioids and attempt and complete suicide. Research from Toronto Western Hospital has confirmed that people with more psychological factors associated with their chronic pain were on about three times the average opioid dose as those without any such factors.

The healthcare system, in many ways, is set up to treat chronic pain and co-morbid mental illness primarily with pharmaceuticals. Focused on a biomedical concept of chronic pain, our system has difficulty accommodating the associated psychological factors. So "we're really overloading our population with pharmaceuticals and this is most obvious with respect to the opioid crisis," he said.

There is doubt that opioids should be used over the long-term to treat chronic pain – defined as pain that lasts at least three months, but is typically a life-long condition. The existing literature on opioids use for the management of chronic pain shows few of the trials on opioid use lasted longer than 12 weeks. "We're looking for efficacy, but we're only looking at three-month periods," he said. Most people using opioids to manage their chronic pain are on these medications for months and years at a time.

In the early 2000s, the idea was that despite the side effects, it was thought opioids worked to some extent for treating pain. While considered effective analgesics, adverse effects included constipation,

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nausea, sedation, and the potential for substance abuse.

This idea was specifically tested in a randomized control trial that was published two years ago in the Journal of the American Medical Association. One of the first studies lasting for more than 12 weeks, it had two pathways. One looked at non-opioid pharmaceuticals such gabapentin or pregabalin – anti-convulsants used typically to treat seizures, but that have been shown to be effective for pain. The other pathway included opioids. The hypothesis was that opioids were going to do better in terms of pain relief, but were going to be limited because of the side effects. In fact, it found people in the non-opioid pathway actually had better pain relief and fewer side effects using drugs that were generic, cheap, and easy to access. This was confirmed in the 2017 Canadian guideline for opioid prescribing for chronic pain which reviewed the cost effectiveness studies for opioids and concluded that anti-inflammatories and anti-convulsants were more cost effective than opioids for the treatment of osteoarthritis and neuropathic pain.

There is another effective pain management tool that has actually been around for decades.

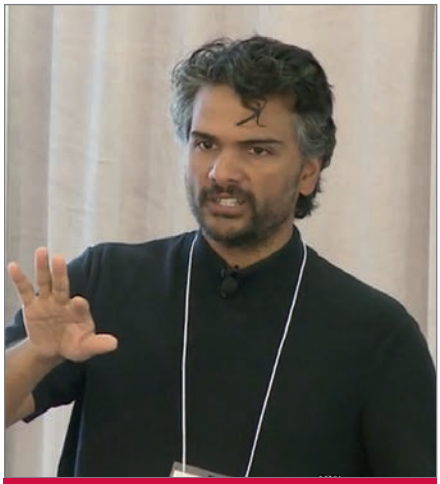
The late D. Gordon Waddell, an orthopedic surgeon, and others popularized a bio-psychosocial approach to treating chronic low back pain in 1987. It dealt with the pain, the experience of the pain, and the suffering that goes with it. This was based on the premise that pain is more than transmission of signals from an injured part of the body to the brain. There is a very important and integral psychological and social component to pain, he contended.

Today, understanding chronic pain as a biopsychosocial problem introduces opportunities for psychological interventions including cognitive behavioural therapy, supportive psychotherapy, and meditation. These have been tested for their efficacy and, when combined, are clearly effective in reducing pain and, importantly, depression.

This is almost the opposite of opioids, he said, which can cause depression not evident before starting opioid therapy.

As a result of this research, there are increasing calls for making these interventions more available.

Chrissy Piraino, Health Solutions Group at Shoppers Drug Mart



Dr. Abhimanyu Sud, WorldCare Guest Speaker, Assistant Professor at the Faculty of Medicine, University of Toronto

However, a major limitation is funding models in the Canadian healthcare system. If an individual on the Ontario Drug Benefit (ODB) plan or even with private insurance comes to his chronic pain clinic, "they certainly have access to pharmaceuticals,w but typically may not have access or reimbursement for these other interventions," he said.

Not only is there evidence that these interventions help, there is also a financial case. Using the ODB as an example, the cost of a typical dose of morphine at 30mg twice per day would be just over a dollar per day. With dispensing fees, that cost per year would be around $500 for a therapeutic of unknown or probably poor efficacy with potential harms. A meditation program his centre will be testing costs $375 and provides benefits in other areas such as, for example, improving sleep and cardiovascular parameters. So there are potentially multiple additional benefits at a reduced cost.

Medication adherence means taking a medication exactly as a doctor prescribed it – at the right time, in the right dosage, and for as long as the doctor recommends, said Michael Roszak, Chief Operating Officer at Express Scripts Canada.

The medical and financial consequences of non-adherence are vast. The ripple effect can lead to lengthier treatments, an increase in hospital visits and duration of stays, and, ultimately, higher drug plan costs for employers when medications are wasted if not used as prescribed.

A number of factors contribute to non-adherence. People may just forget to get a prescription filled because they're busy. Procrastination is another. They know they have to do it, but they'll do it tomorrow. Then tomorrow's busy, so it's put off until next week.

A more complicated reasons for non-adherence is not understanding how or why the medication should be taken. A doctor prescribes a medication, a pharmacist dispenses it, and then an individual is supposed to take it. But this is not always an integrated process where they are communicating with one another.

There are also clinical questions and concerns. The side effects associated with certain disease categories can be a major concern. Some people don't believe the medication will work so they don't take it. Others don't see the treatment as necessary. People also stop taking medications when they don't see an immediate improvement in their health or they stop taking it when they start feeling better.

Lastly, are financial reasons. Some can't afford their prescriptions.

"If we were to bucket these, we would

Michael Roszak, Chief Operating Officer, Express Scripts Canada

say about 70 per cent of the reasons for non-adherence are behavioural, about 20 per cent are clinical, and about 10 per cent are financial," said Roszak.

A break down of claimants reveals the '80-20 rule' – 80 per cent of typical claimants account for about 20 per cent of the spend. The remaining 20 per cent account for 80 per cent of the spend and many of these have chronic diseases and may be dealing with two or more conditions. The spend on the "high flyers" with "multiple conditions, multiple doctors, multiple medications" can top $3,400 on an annual basis, said Roszak.

To tackle this crisis, all the pieces need to be included. The best results come from a personalized approach with strategies designed to improve adherence.

Technology also has a role. There are pill bottles that send a message when opened. It doesn't mean that it's been consumed, but it's an indicator that something is going on. Blister packaging helps those having a hard time remembering if they took their medications or not during the day. Individuals can set alarms as a reminder to take medication and their family members can provide telephone reminders.

And the pharmacist has an integral role to play. They can communicate with their customers if there are problems with medications. They can assist with channel management by offering home delivery where the meds are being sent to an individual before they run out. As well, 90-day supplies can be provided. This helps the procrastinator and can cut non-adherence by a third.

Other measures include auto-refills where the next batch of meds is sent as a prescription runs out; preferred provider networks which enable negotiated agreements around pricing and members access to lower cost alternative networks; and pharmacy value finders that let patients take control of where they get their medications, especially if cost is an issue.

While there are a number of ways to help manage adherence, the dollar issues cannot be overlooked. "All of us are looking for a way to bend the curve a little bit, to make it so drug costs are not increasing at an alarming rate," he said.

Some plan sponsors are turning to formulary management which ensures people have access to the clinically-effective medicines for their conditions at the best prices. Utilization management – such as prior authorizations, step therapy, and preferred pharmacy networks – can also provide some cost relief.

While we all need to be a part of the solution, plan sponsors can save on benefits costs by introducing solutions that are personalized so that adherence rates are improved. Increasing adherence rates by even small amounts may result in significant plan savings.

"There are enough studies out there that show that the avoidance of disability could be a significant savings right across the board. A thoughtful strategy can deliver the extraordinary health benefits that we're all looking for," said Roszak. **BPM**