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FOLLOW THE SCRIPT™

FALL 2016

WHEN LESS IS BEST

Seniors (those age 65 and older) in Canada take more than their share of prescription drugs. As reported by the Canadian Institute for Health Information (CIHI), a great many seniors are taking at least five drugs, and more senior seniors (age 80 or over) and those in long-term care facilities tend to take at least ten drugs.[1]

Often a medication is appropriate at the time it was prescribed but, as a patient's condition changes, it may no longer be the right dosage, the right kind of drug, or required at all. In the case of older people, some drugs aren't suitable or are unsafe – the benefits of the drug may no longer outweigh the risks. As well, when a person is taking many different drugs, there's increased possibility of non-adherence, drug interactions, adverse reactions, and visits to the emergency department.[2]

What can be done to improve this situation? **It's simple: try deprescribing some of those drugs.**

What drugs are we talking about?

There are four drug classes that are common candidates for deprescribing:

- → PPIs (proton pump inhibitors to treat stomach acid problems, such as GERD)
- → Benzodiazepine receptor agonists (sedative-hypnotics)
- → Antipsychotics for sleep
- → Antihyperglycemics (diabetes treatments)[3]

What is deprescribing?

It's pretty much what it sounds like. Deprescribing is the process of tapering, stopping, discontinuing, or withdrawing drugs, with the goal of managing the patient's multiple medications and ultimately improving health outcomes.

To learn more about deprescribing and how it works in real life, we spoke to a pharmacist on the front line: Peter Dumo who is a clinical pharmacist and owner of Novacare Pharmacy in Windsor, Ontario. We also met with Ned Pojskic, GSC's Pharmacy Strategy Leader, to get an overview of the issue and a perspective for our plan sponsors.

Ned explains that,

> "Deprescribing is part of a larger movement of 'de-investing' in tests and treatments to reduce the burden of therapy. The problem isn't just drugs; there are many tests, including diagnostic ones, routinely done that don't necessarily need to be. These are tests and treatments commonly used, but that are not supported by evidence and/or could expose patients to unnecessary harm."

Five prescription drugs

"Polypharmacy" – or taking multiple medications – is a growing issue in older people as the population of seniors increases. But, while seniors represent the bulk of the problem, there are also younger patients taking a number of drugs who could benefit from deprescribing. In his practice, Peter estimates that two-thirds of his deprescribing patients are age 65 or over and one-third is under 65.

Though it's difficult to apply a definitive cut-off number for prescriptions, taking five or more medications is an indication that a patient could be a candidate for deprescribing.[4] However, it's the appropriateness of each drug for that particular patient that's most important.

Why are seniors taking so many drugs they might not need?

Peter finds that older people are frequently prescribed a drug as a result of a visit to the emergency department or a hospital stay. The drug would have been necessary at the time but often the prescription is continued indefinitely – needed or not – as many physicians are reluctant to change another doctor's instructions.[5]

As well, as Ned describes, drugs are typically a physician's first-line treatment, so prescribing can look like this:

- → A patient tells the doctor about some issue they're experiencing.
- → The doctor treats it with a drug.
- → The patient then experiences side-effects from that drug.
- → So the doctor prescribes a drug to combat the side-effects (which are sometimes mistaken for a new disease).[6]
- → Then the patient has more side-effects from the second drug… and so on.

Another prescribing trend for older patients is an increase in the use of medications, such as statins, for preventive purposes. Sometimes these are prescribed without considering the other medications already in use or the patient's prognosis and life expectancy.[7]

Sometimes it seems no one is looking at the patient in a holistic sense that includes the prescription drugs they are taking and why. This is what has led to the "deprescribing movement" over the last few years.

Deprescribing improves lives

There's no question about the value of deprescribing as many patients experience better outcomes and a better quality of life – the drugs might be actually harming them – when the number of medications they're taking is reduced. For instance, their adherence to the remaining medications improves as taking fewer drugs is less complex and easier to follow than taking more drugs. And they are less likely to experience drug interactions or side-effects.[8] Peter has observed that patients appreciate the care and attention they receive at his pharmacy, and they often feel much better once they're taking fewer drugs.

There's also the financial side of this issue to consider as the cost of drugs and the related dispensing fees can quickly add up for both public and private drug plans. And the health care system in general benefits when seniors are healthier, with fewer physician visits and hospital admissions.

Whose job is deprescribing?

As Ned told us,

> "The key is to regularly conduct a holistic review of the medications a person is taking while keeping in mind the possibility of deprescribing."

So who should be doing the reviewing?

The doctor? As Peter commented, "You'd think it should be part of the normal interaction between a family doctor and patient, but sometimes the medication has been started by another practitioner – these patients are often in transition, so they could be seeing specialists or had a hospital stay. It's difficult for the average family doctor to know everything that's happening with a patient. Remember, doctors often have, at most, 10 to 15 minutes to spend with the patient. And today's health care system isn't equipped with a simple means of assessing patients for medication use. Deprescribing is a lot more difficult than prescribing – there's always some detective work involved."

Do pharmacists have the time? In Peter's experience it depends on the pharmacist and the practice. He runs his own practice and has decided to devote the time needed for deprescribing; he's confident that many independent pharmacies see the need and either are doing it now or would embrace the service if they had the means. But many pharmacists are struggling with allocating the necessary time and resources to implement this practice across the board.

Is this an opportunity to join forces? Peter says,

> "I've had tremendous success in working with the local doctors here in Windsor, I approach them as an ally who is trying to investigate a situation with our common patient. Doctors know that people are taking too many meds – they just don't have the resources to do anything about it."

A TIME-CONSUMING PROCESS

Peter outlined the process of deprescribing he follows and the amount of time typically spent with a patient:

- → The initial medication review is usually at least 30 minutes.
- → A pharmacist then has to assess the list and decide what is still benefiting the patient and what needs to be investigated further – that can take 30-60 minutes.
- → Then the pharmacist needs to talk to the patient in-depth about the drugs identified for possible deprescribing and design a plan for stopping or tapering off – potentially another two or three hours.
- → In total, a pharmacist can spend four to five hours with each patient.

Next steps

Ultimately the pharmacist and physician need to work together and collaborate as each has their own area of knowledge and expertise, but there is a need for more education and effective processes to make it happen. The deprescribing movement has a champion in the Bruyère Research Institute where experts are developing guidelines and publications on how to deprescribe; their perspective is that there should be both prescribing guidelines and deprescribing guidelines for every drug.

We here at GSC are strong supporters of deprescribing. With seniors being a growing demographic – by 2036, one in four Canadians will be older than 65 [9] – it's clear there's an opportunity to provide this much-needed service. We see the potential for positive impacts for plan sponsors and their drug plans and for the health care system overall. Currently GSC is supporting the research work undertaken by the Bruyère Research Institute, and we will be sure to revisit this important topic in a future issue of *Follow the Script*.

Sources:
[1] Canadian Institute for Health Information, "Most seniors take 5 or more drugs; numbers double in long-term care facilities," www.cihi.ca/en/types-of-care/pharmaceutical-care-and-utilization/most-seniors-take-5-or-more-drugs-numbers-double. Retrieved: August 10, 2016.

[2,5,6,8,9] Debbie Kwan and Barbara Farrell, "Polypharmacy: Optimizing Medication use in Elderly Patients," *Canadian Geriatrics Society Journal of CME*, Volume 4, Issue 1, 2014, www.canadiangeriatrics.ca/default/index.cfm/journals/canadian-geriatrics-society-journal-of-cme/cme-journal-vol-4-issue-1-2014/polypharmacy-optimizing-medication-use-in-elderly-patients/. Retrieved: August 12, 2016.

[3] Deprescribing Algorithms, deprescribing.org/resources/deprescribing-algorithms. Retrieved: August 10, 2016.

[4,7] Christopher Frank, "Deprescribing: a new word to guide medication review," *Canadian Medical Association Journal*, April 1, 2014, www.ncbi.nlm.nih.gov/pmc/articles/PMC3971020/. Retrieved: August 12, 2016.

DRUG REVIEW AT GSC...

To give you an idea of what drugs might impact your benefits plan next, every quarter *Follow the Script* highlights some of the drugs recently reviewed by GSC's Pharmacy and Therapeutics (P&T) Committee.

GSC CLASSIFICATION[1]	NEW DRUG[2]	GENERAL INFORMATION	COST[3]	COVERAGE DETAILS[4]
CYSTIC FIBROSIS				
High-cost; Specialty	Orkambi™ (lumacaftor/ ivacaftor)	Cystic fibrosis (CF) is a rare and fatal genetic disease affecting children and young adults. The disease impacts mainly the digestive system and lungs – eventually causing destruction of the lungs. Worsening of lung function over time, severe "flare ups" of symptoms, and poor nutrition are the primary causes of hospitalization and eventual death in CF patients. There is currently no cure. An estimated one in every 3,600 Canadian children are born with CF. Currently more than 4,100 Canadians with CF attend specialized clinics.[5] Orkambi is a twice-daily orally administered combination treatment for CF patients age 12 and older who have two copies of a specific mutation (F508del) in the same gene, which produces specific protein defects. Orkambi is the first treatment to target the underlying protein defect. There are currently no treatment options for this group of patients, therefore, Orkambi addresses an unmet need.	$$$$$ Approximately $285,000 per year	→ Specialty drug PPN → Requires prior approval

Notes:

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[1]High-cost refers to drugs subject to GSC's High Cost Drug Policies; Specialty refers to drugs with an expected annual treatment cost of $10,000 or more (certain drugs approaching the threshold may also be considered high cost if clinical evidence warrants).

[2] Brand (generic)

[3] Based on manufacturer list price and estimated pharmacy markup, does not include dispensing fees. $ <1,000; $$ 1,000–4,999; $$$ 5,000–9,999; $$$$ 10,000–49,999; $$$$$ ≥50,000

[4] Applicable to all formularies unless otherwise noted. PPN refers to GSC's preferred pharmacy network program.

[5] About CF, Cystic Fibrosis Canada, www.cysticfibrosis.ca/about-cf

BEHIND THE COUNTER

CATCHING UP WITH PHARMACIST HEALTH COACHING

In each issue of *Follow the Script*, we interview a member of our pharmacy team about a current topic. In this issue, we talk with the newest pharmacist on the team, Marilyn Jung, about her role as GSC's health coaching ambassador.

Follow the Script: Hello Marilyn, welcome to the team. How long have you been with us?

Marilyn: I started at GSC on February 29. I'm a leap-year employee…

FtS: I understand you were a provincial government pharmacist before coming to GSC?

Marilyn: Yes, I worked for Ontario's Exceptional Access Program which allows people to access certain drugs not listed on the Ontario Drug Benefit Formulary. Doctors have to request coverage for their patients, and my job was to review these requests based on the criteria developed by the ministry's drug advisory committee. Often the drugs requested are very expensive or treat rare diseases, so the government wants to be sure they're going to be effective. The program works very much like GSC's prior authorization process.

FtS: And now you've jumped into Pharmacist Health Coaching with both feet…

Marilyn: It's been very exciting. Shortly after starting, I was sent to promote Pharmacist Health Coaching directly to pharmacists at conferences and trade shows. Since cardiovascular health coaching by pharmacists is such a new concept, we've been building it slowly. We're really still in the early stages of rolling out the program.

FtS: Let's remind our readers how the program works.

Marilyn: OK. It's a counselling service for plan members that's delivered by pharmacists who are reimbursed by GSC. The pharmacists are certified to provide plan members with guidance and support in achieving target blood pressure and cholesterol levels and improving medication adherence. They'll also provide coaching to support lifestyle changes that will improve overall cardiovascular health – like nutrition, smoking, and exercise. The program covers four counselling sessions over twelve months.

FtS: Tell us about some of the ways GSC is helping pharmacists to understand the program and encouraging them to get training.

Marilyn: In addition to talking to them at trade shows and conferences, we've sent out letters introducing the program to pharmacists who have a high number of patients eligible to join. We want to make it easier for pharmacists to get on board by explaining how convenient it is to get the training and by offering to send them a list of their eligible patients.

FtS: Have pharmacists mentioned any barriers to participating in the program?

Marilyn: I've found pharmacists to be very enthusiastic about the program. The two main barriers they experience are time constraints and in some cases a lack of eligible patients. It can also be difficult for the pharmacists to convince patients to participate since they're not necessarily used to receiving such services outside of a medical clinic or hospital.

FtS: Those are understandable challenges; do you have any solutions?

Marilyn: One way to compensate for a lack of eligible GSC patients is for the pharmacist to offer the program to all patients as an additional pharmacy service – and charge those patients a fee. Pharmacists who've had the training are welcome to provide counselling to any patient taking medication for high blood pressure and cholesterol; there's no need to restrict it to GSC plan members. There are a lot of people out there who could benefit from cardiovascular counselling. All the informational material is readily available to pharmacists through the providerConnect website, including the patient brochures.

FtS: I know it's up to pharmacists to recruit patients to participate in the program, but is GSC doing any promotion directly to plan members?

Marilyn: Yes, we've just started that part of the project. Plan members who participate in Pharmacist Health Coaching are now receiving bonus codes for the Change4Life® portal. The program is also being expanded to offer plan members the option of getting the coaching over the phone if their community pharmacist isn't offering it. We'll be contacting eligible plan members in the near future.

FtS: I guess we can't do much about pharmacists' time limitations?

Marilyn: Well, no, not directly. But we recently heard from a hospital pharmacist in B.C., Nadeem Zia, who is so excited about the program that he wants to help us get it going. He had read an article in a B.C. Pharmacy Association publication that mentioned the slow initial uptake for the program there. So Nadeem reached out to us to offer to approach pharmacies in his area about the possibility of helping serve their patients. For example, he's prepared to hold Pharmacist Health Coaching clinics at collaborating pharmacies. We sent him a list of pharmacies in his area that have eligible patients and a supply of patient brochures. Now Nadeem intends to contact the pharmacy managers and find out whether they're interested in his support. He really wants to run with this, and we're very impressed with his initiative. We'd love to hear more stories like that or ideas from pharmacists. We even have a special email box set up for them to contact us.

FtS: Any other Pharmacist Health Coaching news to share with us?

Marilyn: Our Pharmacist Health Coaching – Smoking Cessation service was recently updated and launched, so we'll continue to increase promotion of that in addition to the cardiovascular coaching.

FtS: Thanks Marilyn, sounds like we're keeping you busy!