The

INSIDE STORY®

JUNE 2016

What's Inside

WE SAIL INTO UNCHARTED WATERS

GSC TACKLES MENTAL HEALTH

GSC's *The Inside Story* has covered a lot of ground over the years. But one topic has been conspicuously absent—mental health. In the benefits landscape, this issue has been linked mostly to disability management. Canadian plan sponsors' short- and long-term disability portfolios are full of claims with origins that lie in depression and anxiety disorders. If it is not the leading cause of disability claims and costs in your organization, it is probably number two.

So, what possessed a health and dental benefits specialist to turn its attention to mental health? Although we've been silent externally on this issue, we were not quiet inside our four walls. We have been examining drug claims data, consuming research, and debating among ourselves whether there is a fresh perspective we can bring to this critical topic.

Charting our course

The 2015 GSC Health Study is our coming out party. We constructed a chapter entitled "It's All in Our Heads"; not to suggest that mental health issues are imaginary, but to acknowledge the amazing complexity of the human mind, the challenges of accurate diagnosis, and the emerging science related to proper prescribing of antidepressant medication.

Our all-consuming fascination with data is a matter of public record, and our recent examination of antidepressant claims patterns may be the most intense and in-depth study of drug claims we have done yet. Starting last fall, we worked with our data-obsessed friends at Cubic Health Inc. to look at reams of GSC data related to the claiming of antidepressants.

Before the big "unveil" of our analysis, let's share our perspective going into the Health Study:

- The Journal of the American Medical Association (JAMA) published an expansive study in 2010 that suggested the newest generation of antidepressants better served a population of patients with severe depression rather than mild to moderate depression. This suggested that "the system" is likely over-prescribing these drugs to the mild to moderate depression population.

- The study also demonstrated that the mild to moderate depression population is being prescribed very low-level dosages, "sub-therapeutic" to be exact.[1]

- In the broader Canadian health care environment, there is a lack of evidence-based, quality-controlled cognitive behavioural counselling available in our communities, removing from physicians a critical and effective option that is considered a first-line treatment for depression, either alone or in conjunction with medication.[2]

Our mission, which we accepted, was to determine whether our prescription drug claims data would confirm or deny these theories.

Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis

This paper published in JAMA in 2010 reported the results of a study that assessed the effectiveness of antidepressants by analyzing existing drug trial data.

Findings:
"The magnitude of benefit of antidepressant medication compared with placebo increases with severity of depression symptoms, and may be minimal or nonexistent, on average, in patients with mild or moderate symptoms. For patients with very severe depression, the benefit of medications over placebo is substantial."[3]

In other words, antidepressants were minimally effective, if at all, for people with mild to moderate depression; however, antidepressants were much more effective in people with very severe depression.

About the study:

- → It analyzed data from six randomized placebo-controlled trials of antidepressants approved by the U.S. Food and Drug Administration.
- → Each trial included a medication versus placebo comparison for at least six weeks.
- → A total of 718 adults were studied; they had been diagnosed with minor to major depressive disorder.
- → Three of the trials were for a selective serotonin uptake inhibitor (SSRI) and the other three trials were for a tricyclic medication (an older type of antidepressant).[4]

Buckle up, here are the GSC numbers...

Step One: We identified **350,000** GSC plan members who, over a three-year study period, had continuous prescription drug coverage and experienced no change in plan design. Yes, a "clean" sample for doing our assessment.

Step Two: In that three-year study period we identified **35,000** of those plan members who started on an antidepressant (we call them "new starts"). Those are the folks we zeroed in on to determine what we could learn from the prescribing and claiming patterns we had in our data.

So let us tell you the story of the 35,000 "new starts." We divided this large group into two—one group we called Treatment Resistant Depression (TRD), the other group we called Monotherapy. (Look at us, sounding all sciencey!)

Treatment-resistant depression describes cases of more stubborn, more significant depression that have been tried on multiple medications and dosages.

Monotherapy means the treatment of a condition by means of a single medication.

The TRD group

Let's talk about the TRD group. What jumps out in the claims data first and foremost is that these plan members try more than one antidepressant, and we see changes in dosages over the course of their claims history; this suggests robust follow-up. What is evident is a physician trying to determine the best drug regimen for a complex and very sick patient. And that's good to see—clear efforts to treat what we believe are the severely depressed population cited in the JAMA study above.

continues...

But, take note, this group makes up only 12 to 15 per cent of those 35,000 new starts on antidepressants in the three-year study period—a distinct minority. If there are headlines to be written from our mental health analysis, they do not lie here. We believe the evidence in our data suggests this group is getting adequate care. But there are many more question marks related to our Monotherapy group…

The Monotherapy group

This group comprised 85 to 88 per cent of the 35,000 new starts on antidepressants in the three-year study period. This is the vast majority of our study group.

Those of you who remember studying ancient Greek in high school know that "mono" means single or one (and if you took ancient Greek, it means you're old). And our Monotherapy group had a clear profile in the GSC claims data. This group of plan members is prescribed a lone antidepressant, frequently at a sub-therapeutic dose, and a large proportion of them drop off the medication soon after therapy starts. This is a very concerning pattern. Very.

More on the TRD group:

- → Average age is 45.
- → They are high-cost claimants, definitely part of the top five per cent of plan members that account for 50 per cent of GSC drug expenditures (see the May issue of The Inside Story for more).
- → Only 35 per cent of their drug spend is for antidepressants, 65 per cent is for drugs related to hypertension, cholesterol, and diabetes—a roll call of chronic disease.
- → They have the highest rates of adherence to antidepressants that we have ever identified—over 60 per cent—nothing to write home about, but materially higher than the 45 per cent adherence we see in the general GSC antidepressant population.

Time to dive in…

First let's define what "sub-therapeutic" means, because that word is in our potential headlines from the study. There are clear guidelines for physicians on prescribing medications. In those guidelines, it states the levels at which the drug starts to have an impact on humans. We saw prescriptions below that level in **44 per cent** of our plan members starting on antidepressants. (It's appropriate for our readers to mouth the word "wow" at that number.) The rest of the group looks like this:

- → 50 per cent of the monotherapy group received a starting dose at the minimum therapeutic level.
- → Six per cent were prescribed above the minimum therapeutic level.

Earlier we suggested that a substantial number of the Monotherapy plan members dropped off their antidepressants rapidly—specifically within the first 135 days. This data must be presented with the knowledge that it is generally recommended that a patient continue on an antidepressant for six months following the resolution of symptoms.[5]

On that front, 26 per cent of the plan members receiving a sub-therapeutic first dose did not fill a second prescription. Therefore, they were likely on the medications for 30 days and then off. And 68 per cent were off their medications before 135 days passed. Of the group receiving the minimum therapeutic dose, 25 per cent did not have second fill, and 20 per cent of the above therapeutic dose group never filled twice.

So what are the numbers telling us?

We started this article by recognizing the complexity of treating mental health. As we have presented this data across Canada over the spring, we have been careful around the conclusions we draw. There are no CT scans, MRIs, or blood tests for physicians to rely on to help diagnose mental health. And the prescribing of antidepressants is less predictable in its results than prescribing a statin for hypertension or cholesterol. So we have been careful to present the numbers in a way that doesn't lead to a position that doctors, likely family physicians in the majority of these cases, are failing to properly treat patients with depression and/or anxiety.

Let's try to define some fair and balanced learnings...

We see a mental health eco-system where family physicians do not have a robust toolkit. Is the prescribing of a sub-therapeutic dose a natural outcome when a physician is faced with a patient needing support—a patient who is not severely depressed or anxious, but going through a temporary period when support and treatment is needed? The physician's first instinct may be to refer a patient to cognitive behavioural counselling but the truth is, it is simply not widely available. And we as patients, in our modern world, expect our doctors to *do something*. To that end, a sub-therapeutic dose prescribed by that physician is not likely harmful to the patient, but our concern from the study is that it is *not helpful*. We have now had the opportunity to share these results with physicians—both family doctors and psychiatrists—and they agree that this is the dilemma physicians face in their day-to-day practice.

Our readers know we have a history of mining our data to identify the costs that drive our health benefits plans. We have also done our best to take the next step and try to determine whether concrete health outcomes result from that investment in health benefits.

So, yes, the headline here is that we are investing a lot of dollars in antidepressants that are not having a downstream impact on plan member health. GSC reimbursed $45 million in antidepressants last year. A significant portion of that spend reflected the prescribing patterns demonstrated in this new data.

Back to our talk about a physician's toolkit. Imagine a system where evidence-based, quality-controlled cognitive behavioural therapy did exist for Canadians. And the dollars currently spent on un-impactful drug therapy were invested in that. That is what research tells us will be more effective for portions of the mild to moderate depression population.

What now?

At a time in our country when we have highly impactful campaigns telling people to put up their hands and seek out care for mental health issues, it would be terrific if the care they were met with was far more effective.

Is to try to figure out the path to get to that better place—and here is a warning:
Now that we have broken our silence on mental health, you may not be able to shut us up.

Sources:

[1,3,4] Jay C. Fournier, M.A., Robert J. DeRubeis, Ph.D, Steven D. Hollon, Ph.D., Sona Dimidjian, Ph.D., Jay D. Amsterdam, M.D., Richard C. Shelton, M.D., and Jan Fawcett, M.D., "Antidepressant Drug Effects and Depression Severity: A Patient-Level Meta-Analysis," JAMA, January 6, 2010, Vol. 303, No.1. Retrieved May 30, 2016: jama.jamanetwork.com/article.aspx?articleid=185157#METHODS

[2,5] Sidney H. Kennedy, Raymond W. Lam, Sagar V. Parikh, Scott B. Patten, Arun V. Ravindran, "Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical guidelines for the management of major depressive disorder in adults," *Journal of Affective Disorders*, August 2009. Retrieved June 7, 2014: http://www.canmat.org/resources/CANMAT%20Depression%20Guidelines%202009.pdf

COMMUNITY GIVING PROGRAM

HERE'S HOW WE **ADD** TO THE **GREATER GOOD**…

Paving the way for a brighter future
Take a look at how our grant recipients are making a difference

Frontline care—like dental services, vision care, prescription drugs, disease management, and mental health supports—can act as a catalyst for change. That's why the GSC Community Giving Program is focused on supporting organizations and initiatives that provide frontline care for underinsured or uninsured populations. And all grant recipients include a navigator component—this means ongoing positive change as clients are referred to any additional services they may need.

Frontline care in action throughout Ontario

GSC frontline care™

Cornerstone Housing for Women Foundation – Navigating the Transition
The Foundation provides emergency shelter and housing for homeless women in Ottawa, in an environment that promotes dignity and hope. GSC funding made it possible for the Navigating the Transition program to hire a navigator to provide support for women transitioning to permanent housing. To learn more, visit www.cornerstonewomen.ca.

Community Care City of Kawartha Lakes – Project Smiles
Community Care City of Kawartha Lakes (CCCKL) provides a range of health and support services for people of all ages in the City of Kawartha Lakes. GSC funding is helping the CCCKL Dental Clinic's Project Smiles program provide affordable dental care for low income seniors and families. To learn more, visit www.ccckl.ca.

LOFT Community Services – Jane and Finch Transitional Age Youth Program
LOFT offers a wide range of mental health support, addiction services, and housing units for people in Toronto, York Region, and South Simcoe who have mental, physical, and substance abuse issues. GSC funding enabled LOFT to pilot its Transitional Age Youth Program (TAY) in Toronto, which supports youth with mental health issues and addictions and helps homeless youth find safe and affordable housing. To learn more, visit www.loftcs.org.

South Riverdale Community Health Centre – Non-Insured School Program
The Centre provides health care services and health promotion programs to improve the lives of people in southeast Toronto who face barriers to physical, mental, spiritual, and social well-being. GSC funding made it possible for the Centre to hire a navigator to help people address their unique health and social needs. To learn more, visit www.srchc.ca.

Dave Smith Youth Treatment Centre – Increasing Health Outcomes for Youth Dealing with Substance Abuse and Mental Health Issues
The Centre helps youth and families across Ontario to overcome substance abuse, mental health and related issues. GSC funding is enabling the Centre to hire a nurse practitioner for each residential campus to provide primary health care onsite for vulnerable at-risk youth who are struggling with substance abuse. To learn more, visit www.davesmithcentre.org.

What's UP...

REPORT EXPLORES PRESCRIPTION DRUG EXPENDITURES IN CANADIAN PUBLIC PLANS

The second edition of *CompassRx*—the Patented Medicine Prices Review Board's annual report that analyzes drug trends in Canada's public plans—provides insight regarding the 2013/14 fiscal year including a review of trends since 2009/10.

The report explains that changes in prescription drug expenditures are driven by a number of opposing "push" and "pull" forces. The "push" effect—pushing up expenditures—is made up of variables like an increase in the population using public drug plans, an increase in drug use, and/or an increase in use of more expensive drugs. The "pull" effect—pulling expenditures down—is made up of variables like generic substitutions and price reductions. The impact of each variable differs year by year; as a result, prescription drug expenditures change over time and may differ across public drug plans.

The report indicates that in 2013/14 spending by Canadian public drug plans increased by an average of 2.0%, reversing a trend of low or negative drug expenditure growth. The "push" effect driving expenditures up was the use of higher-cost drugs such as biologics, as well as the "pull" effect of substantial reduction in savings from the use of lower-priced generic drugs. In addition to increased spending on high-cost drugs, most public drug plans have been spending more on dispensing costs, which grew by 5.9% in 2013/14.

For more information and to download the report visit www.pmprb-cepmb.gc.ca/view.asp?ccid=1258.

GLOBAL SURVEYS PROVIDE INSIGHT INTO HEALTH CARE TRENDS

Four recent health care surveys by Willis Towers Watson reflect the viewpoints of three stakeholders—insurers, employers, and employees—and reveal five predominant themes:

- → A rising trend in medical costs continues to be a major issue for employers,
- → This trend of rising medical costs is driven by over-utilization and provider practices but is also due to chronic health issues throughout populations globally,
- → Employers must develop a coordinated strategy to manage utilization and provider practices and to promote employee health and well-being,
- → Each employer must understand their organization's specific issues so that their strategy is effective, and
- → Vendors that provide support for employers in all these areas will dominate.

- → **2016 Medical Trends Survey:** opinions of insurance carriers in 55 countries about trends in medical costs.
- → **2015/2016 Staying@Work Survey:** opinions of employers in 34 countries about employee health and wellness and the activities they are undertaking.
- → **2015/2016 Global Benefits Attitudes Survey:** opinions of 30,000 employees worldwide about employer-sponsored health benefits, and the role of employers in health and wellness, consumerism, and stress.
- → **2016 Benefits Data Source Survey:** data on employer-sponsored plan designs covering more than 100 countries.

For more information and to download the reports, visit www.willistowerswatson.com/en/insights.

NOW REGISTERING FOR PLAN MEMBER ONLINE SERVICES IS JUST ONE SIMPLE STEP

With our simplified registration process, it's easier than ever (while ensuring optimal security!) for plan members to sign up for Plan Member Online Services. Now it's just one step—plan members input a few personal details, as well as their registration key (included with with claim statements) and presto, that's it! Their online account makes accessing and managing their GSC benefits plan quick, convenient, and easy. Encourage your plan members to register today at https://onlineservices.greenshield.ca/PlanMember/AccessMgmt/Public/SignOn.aspx.

There's a lot for plan members to look forward to online:

- → Submit claims (for plans that allow online claims submission)
- → Sign up for direct deposit
- → View claim history and statements
- → Check eligibility

...And more! They can access the Change4Life portal and download the GSC on the Go app.

June Haiku

It's all in our heads
Complex challenges face us
Action needed now

WINNER OF THE DRAW FOR A FITBIT

Congratulations to **K. NEWARK**, of **Guelph, Ontario**, the winner of our monthly draw for a Fitbit. Through this contest, one name will be drawn each month from plan members who have registered for Plan Member Online Services for that month.

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