Pharmacy benefit managers can combat the increased costs and poor health outcomes that result from plan members who don’t take medications as prescribed.
Here is a lot of buzz these days in the Canadian health benefits industry about innovation: innovative ideas, innovative approaches, innovative solutions.

Trends such as an aging population, expiring brand-name drug patents, emerging biologics and competing stakeholder agendas are making innovation a necessity. Benefits plans that develop innovative strategies will improve plan member health while containing costs. Those that don’t, won’t—No innovation means stagnation.

A model example is the struggle to bring the issue of medication nonadherence to centre stage. The World Health Organization (WHO) defines adherence as “the extent to which a person’s behaviour—taking medication, following a diet, and/or executing lifestyle changes, corresponds with agreed recommendations from a health care provider.” Specifically, regarding medication, WHO describes adherence as the “use of appropriate agents, correct dosing and timing, filling and refilling prescriptions, consistency of use, duration of use.”

We have heard very little about the high incidence of medication nonadherence, despite research confirming that it has resulted in increased drug costs and decreased plan member health. In fact, in addition to the negative consequences of nonadherence, we also don’t seem to seriously acknowledge the positive outcomes of adherence. We’ve been lulled into a state of complacency.

But pharmacy benefit managers (PBMs) can challenge this historically lackadaisical approach. And to be innovative, everything must come under the microscope: data, strategies and roles.

Look at Data Differently

Constant monitoring of a health plan’s drug spend is an important part of assessing current cost trends, as well as defining policies and charting future plans. For this reason, a cornerstone of drug oversight has traditionally been to examine top drug lists—a straightforward tally of the most expensive individual medications.

But is the drug list telling the whole story about plan member health? Instead of just looking at drug costs, PBMs can also look at drug categories by examining each plan’s top therapeutic classes.

For example, high-cost drugs often are taken by relatively few plan members, whereas the top therapeutic classes can reveal disease states that affect a large number of plan members and drive the vast majority of plan sponsor costs. And although the top therapeutic classes might include different disease states, it is important to note which are chronic health conditions.

This can provide important insight into more effective plan management, as future strategies could be developed to target the health issues affecting the largest number of plan members. Most chronic health conditions require strict adherence to drug therapy as part of an overall treatment plan. So the next question is, “Are plan members with chronic health conditions adherent to their medications?”

Green Shield Canada’s 2012 Drug Study revealed that almost 40% of plan members with high blood pressure are nonadherent, and this group costs plans three times as much as those not receiving treatment. In addition, more than 40% of plan members with high cholesterol are nonadherent, costing their plans 3.5 times as much as those...
without the condition. Similarly, more than 50% of plan members with depression are nonadherent, costing their plans 3.5 times as much as those without depression.

When we consider that, with our aging population, chronic conditions are on the rise, medication nonadherence becomes a priority issue.

**Look at Strategies Differently**

Traditionally, our default behaviour has been to focus automatically on enhancing established strategies, such as with generic drug substitution, managed formularies, drug prior authorization and provincial drug plan coordination programs. Although this approach is important, it does not bring anything new to the mix.

PBMs should resist the urge to automatically examine issues using established schools of thought. For instance, regarding medication nonadherence, many ask, ”Is addressing medication nonadherence a wellness program or is it a health provider initiative or is it a cost-containment strategy?” The answer is “all of the above.” This sort of untraditional thinking can open the door to new ideas that fall across strategic categories and along all areas of the drug delivery model.

Such multistrategy and multitarget-group approaches are particularly suited to the complicated nature of medication nonadherence, which requires engaging not only plan members, but also all stakeholders along the drug delivery model. As WHO describes, “Adherence is a complex behavioural process determined by several interacting factors. These include attributes of the patient, the patient’s environment (which comprises social supports, characteristics of the health care system, functioning of the health care team, and the availability and accessibility of health care resources) and characteristics of the disease in question and its treatment.”

**Look at Roles Differently**

A major barrier to providing optimal care is the “skill silo,” where health care professionals get pigeonholed as having the ability to offer only a certain skill. This is confining and results in limiting their contribution.

PBMs can think differently by looking at how to leverage the skills of pharmacists—all skills, not just the skills traditionally relied on.

Research indicates that most smokers make multiple quit attempts before successfully becoming nonsmokers. A big part of what makes a successful quit attempt versus an unsuccessful one is the smoker’s ability to adhere to his or her smoking-cessation drug regimen. In addition, research continues to show improved success rates when smoking-cessation drug therapy is combined with patient support in the form of counselling.

A pharmacist-supported smoking-cessation program included an initial assessment where the pharmacist recommended the most appropriate smoking-cessation drug. The pharmacist then provided six followup counselling sessions with the plan member in person or over the phone. The program realized a self-reported six-month quit rate of 37.5%.

Results such as these confirm that pharmacists are skilled at providing behavioural support. In this case, pharmacists trained in smoking-cessation counselling were highly effective in helping patients quit smoking. What about the role of pharmacists with chronic conditions like hypertension and diabetes? When we consider that the effective management of all chronic conditions relies on medication adherence, there is a clear role for pharmacists beyond simply filling plan member prescriptions.

Addressing medication nonadherence can only be a success if we think differently; enhancing the status quo isn’t enough. Whether medication nonadherence or other critical health plan issues, an innovative mindset will enable us to proactively address our complicated environment to manage costs while ensuring plan member health."