Introductory session

Dr Anthony Bewley
Housekeeping

- Please switch off mobile phones
- This is an interactive workshop – questions are welcomed
- Your LEO representative can assist you
- This is a ‘train the trainer’ programme – you are already experts
<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Speaker</th>
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</thead>
<tbody>
<tr>
<td>08:30 – 08:40</td>
<td>Session opening</td>
<td>Dr Anthony Bewley</td>
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<tr>
<td>08:40 – 09:15</td>
<td>Introductory session</td>
<td>Dr Anthony Bewley</td>
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<tr>
<td>09:15 – 09:45</td>
<td>Why does communication and consultation style matter</td>
<td>Dr Catherine Hood</td>
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<td>09:45 – 10:00</td>
<td>Refreshment break</td>
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<td>10:00 – 12:00</td>
<td>Patient profiling module</td>
<td>Dr Anthony Bewley</td>
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<td>12:00 – 12:45</td>
<td>Lunch</td>
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<td>12:45 – 14:45</td>
<td>Building relationships and managing expectations</td>
<td>Dr Catherine Hood</td>
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<td>14:45 – 15:00</td>
<td>Refreshment break</td>
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<td>15:00 – 16:00</td>
<td>Role-play exercise to combine learnings</td>
<td>Dr Catherine Hood</td>
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<td>16:00 – 16:50</td>
<td>Call to action</td>
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<td>National roll-out experience in Japan</td>
<td>Professor Masatoshi Abe</td>
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<td>National roll-out experience in China</td>
<td>Dr Xibao Zhang</td>
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<td>National roll-out experience in GCC regions</td>
<td>Professor Sameer Zimmo</td>
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<td></td>
<td>Planning of national roll-out</td>
<td>All</td>
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<tr>
<td>16:50 – 17:00</td>
<td>Session closing</td>
<td>Dr Anthony Bewley</td>
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Video
Discussion point

• What do you think are the key issues leading to non-adherence?
• Discuss in your groups and make some notes
Rationale for Psoriasis Academy programme

• World Health Organization (WHO) recognises adherence in chronic diseases as one of the most important factors contributing to an efficient therapy

• Poor adherence and subsequently suboptimum therapeutic results leads to increased costs

• Any intervention leading to improved adherence is regarded as beneficial

What is adherence?

• Definition of adherence
  • The degree to which patients use medication as prescribed by healthcare professional (HCP), based on good communication between patient and provider
  • It requires the patient’s agreement

• What are the benefits of improving adherence in psoriasis?
  • Happier patient
  • Improved HCP satisfaction
  • Personal, economic and societal
Communication is key

• How we communicate information to patients about their disease and treatments is key to improving adherence:

- Informed and engaged patients stand a better chance of managing their psoriasis effectively.
- Patients can be empowered through interaction and communication with their HCP.

• Psoriasis Academy aims to equip you to teach others about communication strategies that improve adherence.

• The Academy will offer training, resources and processes that support HCPs to empower their patients to take control of their condition.
Note to delegates: The Toolkit

• Throughout the academy we will refer frequently to the toolkit, which will be made available on the Psoriasis Academy Website
• The toolkit is a descriptive compilation of assessments and interventions that can be used during consultations
• It covers tools for assessing psoriasis skin severity, health-related quality of life, adherence behaviour, treatment benefit, and psychological burden, as well as resources to support patients
• It will be made available to delegates on the Psoriasis Academy Website as part of the key materials and ongoing support the Psoriasis Academy will provide
Psoriasis is more than a skin condition

Figure 1. The spheres of psoriasis disease. CVD, cardiovascular disease; QoL, quality of life; BoD, burden of disease.

Figure reproduced from Mrowietz et al. Exp Dermatol 2014;23:705-709
## Selected associations in Asian and European patients with psoriasis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Taiwan Relative risk (95% CI)¹</th>
<th>Germany Prevalence ratio (95% CI)²</th>
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<tbody>
<tr>
<td>Arterial hypertension</td>
<td>1.51 (1.47, 1.56)</td>
<td>1.73 (1.71, 1.76)</td>
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<tr>
<td>Diabetes</td>
<td>1.64 (1.58, 1.70)</td>
<td>2.02 (1.96, 2.08)</td>
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<tr>
<td>Dyslipidaemia</td>
<td>1.61 (1.54, 1.68)</td>
<td>1.75 (1.72, 1.78)</td>
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<tr>
<td>Ischaemic heart disease</td>
<td>1.32 (1.26, 1.37)</td>
<td>1.87 (1.82, 1.92)</td>
</tr>
<tr>
<td>Rheumatoid arthritis</td>
<td>3.02 (2.68, 3.41)</td>
<td>3.84 (3.43, 4.31)</td>
</tr>
<tr>
<td>Depression</td>
<td>1.50 (1.39, 1.61)</td>
<td></td>
</tr>
<tr>
<td>Fatty liver</td>
<td>2.27 (1.90, 2.71)</td>
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1. Tsai et al. J Dermatol Sci 2011;63:40–46 (51,800 psoriasis cases; >400,000 age- and gender-matched controls)
2. Augustin et al. Acta Derm Venereol 2010;90:147–151 (33,981 psoriasis cases; 1,310,090 controls)
## Selected associations in juvenile and adult patients with psoriasis

<table>
<thead>
<tr>
<th></th>
<th>Children Prevalence ratio (95% CI)¹</th>
<th>Adults Prevalence ratio (95% CI)²</th>
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<tbody>
<tr>
<td>Arterial hypertension</td>
<td>1.89 (1.47, 2.67)</td>
<td>1.73 (1.71, 1.76)</td>
</tr>
<tr>
<td>Diabetes</td>
<td>2.01 (1.32, 3.04)</td>
<td>2.02 (1.96, 2.08)</td>
</tr>
<tr>
<td>Hyperlipidaemia</td>
<td>2.15 (1.65, 2.80)</td>
<td>1.75 (1.72, 1.78)</td>
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<tr>
<td>Obesity</td>
<td>1.70 (1.49, 1.93)</td>
<td>1.72 (1.68, 1.76)</td>
</tr>
<tr>
<td>Ischaemic heart disease</td>
<td>1.52 (0.97, 2.38)</td>
<td>1.87 (1.82, 1.92)</td>
</tr>
<tr>
<td>Rheumatoid arthritis/juvenile idiopathic arthritis</td>
<td>5.21 (1.40, 19.44)</td>
<td>3.84 (3.43, 4.31)</td>
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<tr>
<td>Crohn’s disease</td>
<td>3.69 (2.15, 6.35)</td>
<td>2.06 (1.84, 2.31)</td>
</tr>
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</table>

¹. Augustin et al. Br J Dermatol 2010;166:633–636 (2549 cases; 331,758 controls)
². Augustin et al. Acta Derm Venereol 2010;90:147–151 (33,981 cases; 1,310,090 controls)
The importance of effective treatment

- Treatments are used to control skin lesions and systemic inflammation/comorbidity
- Treatments include:
  - Topical therapies
  - Systemic therapies
  - Light therapies
- In a study\(^1\):
  - Only 25% patients considered their treatment to be effective
  - 30% had some degree of dissatisfaction with treatment
  - 45% were entirely dissatisfied with treatment efficacy

Low levels of treatment satisfaction can lead to a vicious cycle of poor adherence, poor efficacy and increased dissatisfaction

\(^1\) LEO Pharma, Red Associates Report, 2010. Unpublished internal data
Adherence: a challenge in chronic skin conditions such as psoriasis\(^1\)

- Overall adherence to therapy ranged from 22 to 67\(^2\)
- Primary adherence: redemption of initial prescription
  - In patients prescribed an initial treatment with a previously untried medication, patients with psoriasis were the least adherent, with almost 50% failing to redeem their first prescription\(^3\)
- Secondary adherence\(^4\)
  - Incorrect use of medication → 39–73%
  - Under-dosage of topical medication → 95%
  - Recommended dose applied → 35%

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Poor adherence to treatment of chronic diseases is a worldwide problem

- In developed countries, adherence among patients suffering chronic diseases averages only 50%.
- In developing countries, it is assumed that the magnitude and impact of poor adherence is much worse.

The challenge of poor adherence is likely to rise in magnitude with the continued increase in chronic disease prevalence.

WHO [http://www.who.int/nutrition/topics/2_background/en/](http://www.who.int/nutrition/topics/2_background/en/) [date accessed August 2015]
What impact does non-adherence to treatment have in clinical practice?

**Unfavourable disease outcome**\(^1,2\)

- Meta-analysis of 63 studies (19,456 patients) demonstrated that adherence (vs non-adherence) to treatment reduces the risk of a null or poor treatment outcome by 26%\(^1\)

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What impact does non-adherence to treatment have in clinical practice?

• **Inappropriate therapeutic decisions due to underestimation of treatment efficacy**¹⁻³
  • Potentially leads to an overestimation of the dosage requirement and subsequently to increased adverse reactions to the prescribed medication¹,²
  • Change in therapy³

What impact does non-adherence to treatment have in clinical practice?

• **Increased costs for the health system**¹,²
  • Increase in preventable emergency department visits and inpatient hospitalisation¹
  • Unnecessary sale of expensive medications²

Adherence to dermatology treatment is multi-faceted

- Social / Economic Factors
- Patient-related Factors
- Relationship to Healthcare Professional
- Therapy-related Factors
- Condition-related Factors

Which adherence factors can and cannot be influenced?

**FIVE DIMENSIONS OF ADHERENCE**

- Social/economics factors
- HCP-/system-related factors
- Disease-related factors
- Treatment-related factors
- Patient-related factors

HCP, healthcare professional
Which adherence factors can and cannot be influenced?

FIVE DIMENSIONS OF ADHERENCE

Social/economics factors
HCP-/system-related factors
Disease-related factors
Treatment-related factors
Patient-related factors

FACTORS AFFECTING ADHERENCE

eg age, gender, education, social stigma, employment, financial security, marital status

HCP, healthcare professional
Which adherence factors can and cannot be influenced?

FIVE DIMENSIONS OF ADHERENCE

- Social/economics factors
- HCP-/system-related factors
- Disease-related factors
- Treatment-related factors
- Patient-related factors

FACTORS AFFECTING ADHERENCE

eg unclear dosage instructions, lack of communication, time constraints

HCP, healthcare professional
Which adherence factors can and cannot be influenced?

FIVE DIMENSIONS OF ADHERENCE

- Social/economics factors
- HCP-/system-related factors
- Disease-related factors
- Treatment-related factors
- Patient-related factors

FACTORS AFFECTING ADHERENCE

eg visual lesions, number of lesions

HCP, healthcare professional
Which adherence factors can and cannot be influenced?

FIVE DIMENSIONS OF ADHERENCE

Social/economics factors
HCP-/system-related factors
Disease-related factors
Treatment-related factors
Patient-related factors

FACTORS AFFECTING ADHERENCE

eg time-consuming, cosmetic and galenic issues, formulation vehicle, frequency of application, slow absorption, duration of treatment, side effects

HCP, healthcare professional
Which adherence factors can and cannot be influenced?

FIVE DIMENSIONS OF ADHERENCE

Social/economics factors
HCP-/system-related factors
Disease-related factors
Treatment-related factors
Patient-related factors

FACTORS AFFECTING ADHERENCE

eg perceived ineffectiveness, lack of expected effects, lack of disease- and therapy-related knowledge, being busy, being fed up, psychological, treatment satisfaction, forgetfulness, failure to redeem prescriptions

HCP, healthcare professional
Types of non-adherence: unintentional and intentional

**Unintentional**

Patient is prevented from following treatment plan due to barriers beyond their control:

For example:
- Lack of understanding instructions
- Problems with using treatment
- Inability to pay
- Forgetfulness

**Intentional**

Patient deliberately decides not to follow treatment recommendations:

For example:
- Motivation
- Patient beliefs (e.g., severity of disease)
- Treatment preferences
- Interference with daily routine

Patient behaviour determines adherence to treatment

Impact of non-adherence: inappropriate therapeutic decisions

• If HCPs wrongly assume that their patients have taken prescribed medication(s), they may make inappropriate medication and/or dosage changes if treatment is thought to be non-efficacious
  • This can result in further complications (eg adverse reactions to newly prescribed medication) and suboptimal health outcomes

• As such, patients fail to benefit from effective medication, and risk being harmed by less than ideal medications and dosage choices

Impact of non-adherence: increased economic burden

• In a comparative study of 108 adherent and non-adherent patients with psoriasis, improved adherence led to more rapid clinical improvement and lower treatment costs (p=0.001)¹

• Non-adherence contributes to a significant amount of unnecessary medical/drug expenditure²

Impact of non-adherence: increased economic burden

• In a study of dispensed prescription drugs in the entire Swedish population during a 12-month period, acquisition costs related to non-adherence totalled €1.2 billion (48.5% of total drug acquisition costs in Sweden, data from 2006)¹

• A retrospective, longitudinal study of patients aged >60 years demonstrated that non-adherence to therapy was associated with subsequent emergency department visits²


Poor or non-adherence leads to worsening of psoriasis, with these patients often reporting poorer health, ultimately leading to additional healthcare resource utilisation to regain management of the disease³
Cultural beliefs play a significant role in treatment adherence

• Cultural beliefs play a significant role in medication-taking behaviours and may often be overlooked by HCPs\(^1\)

• Culture is defined as the system of values and norms shared by a group or society, and may include patterns of behaviour, beliefs, customs, religions and traditions\(^1,2\)

• Some cultures may replace their prescribed conventional ‘western’ medication for more traditional homeopathic medicines, or other methods of healing, eg faith healing\(^3\)

Identifying specific adherence challenges

Research identified four basic patient types in psoriasis

- **Self-manager**: 40%
- **Actively engaged**: 16%
- **Why me?**: 28%
- **Help me**: 16%

Understanding these patient types may benefit HCP–patient communication

- Grouping patients according to key behaviours and characteristics will support HCPs in their engagement with patients, helping them to:
  - Target medication more appropriately
  - Refer patients as necessary for psychological assessment/therapy
  - Provide empathy, emotional support and educational resources
Understanding these patient types may benefit HCP–patient communication

Research indicates that patients belonging to the ‘Why me’ and ‘Help me’ profile types*:

- May have a more negative relationship with their HCP
- Tend to be the least satisfied with topical treatments (due to onset of action, fear of side effects)
- ‘Help me’ profile may have more concomitant conditions and have a greater propensity to anxiety, depression, insomnia and arthritis

*Based on research insights (5+ years, ~6000 patients), data for 1884 of these patients published in Bewley et al. J Eur Acad Dermatol Venereol 2014;28:763–770
Understanding these patient types may benefit HCP–patient communication

• A good HCP–patient relationship and inclusion of patients in therapy decisions (joint planning approach) may help to improve treatment adherence and patient satisfaction\(^1,2\)

• This requires sufficient time at each visit to explain the use, benefits and possible side effects of medications

Benefits of a person-centred care approach

- Improved quality of life
- Improved survival
- Improved treatment outcomes

- Reduced care disparities
- Reduced care costs

Levinson et al. Health Affairs 2010;29:1310−1318
Patient education and motivation: role in long-term management of chronic skin diseases

- Successful patient education increases patient satisfaction and improves health outcomes and adherence to treatment\(^1,2\)

- In a randomised controlled trial, 50 patients with psoriasis or atopic dermatitis were randomised to the intervention (12-week educational programme) or control group\(^3\)

- Patient education contributed to improved disease severity and quality of life in patients with psoriasis\(^3\)


Figures reproduced from reference 3
Am I motivating change? It is a wasted opportunity if we are not doing it in the correct manner. If that will make a difference, then it’s absolutely worth the training\(^1\)

I’ve had pretty much no advice other than... let’s try this treatment. So, no lifestyle advice or anything like that\(^2\)

Who is involved with managing patients with psoriasis?

This programme focuses on HCPs and their relationships with patients.
International support

- **International Federation of Psoriasis Associations** – [www.ifpa-pso.org](http://www.ifpa-pso.org)
  - A non-profit federation made up of psoriasis associations from around the world
  - Aims to secure universal access to treatment, raise awareness and understanding of psoriasis, and change treatment paradigms
  - Provides links to national patients’ associations
HCP–patient interactions

Expectations/understanding influence treatment adherence

Differences in HCP and patient expectations/understanding are:\(^1\)
  o Treatment goals
  o Need for education
  o Content and quality of first visit
  o Importance of maintenance treatment

Improving the HCP–patient relationship can improve medication adherence:\(^2,^3\)
  o A patient’s trust in a HCP is linked with effective communication
  o Trust can be increased if HCPs:
    • Show patients they understand the burden of their illness
    • Listen to patients’ concerns
    • Physically examine patients’ skin

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Summary

• Treatment adherence is recognised as a specific challenge to the effective treatment of inflammatory skin conditions such as psoriasis

• Non-adherence to treatment is associated with poor clinical outcomes, may foster inappropriate therapeutic decisions and can result in increased healthcare costs

• There are many reasons for patients not adhering to treatment, both intentional and non-intentional:

  - Social and economic
  - HCP and system related
  - Patient related
  - Treatment related
  - Disease related

Summary

• Research has identified four key patient profiles: (1) **Self-manager** (2) **Actively engaged** (3) **Why me?** (4) **Help me**
  
  • Different patient profiles have different medical and treatment needs

  • Understanding these needs may help to improve treatment adherence via appropriate channels (eg targeting of treatments, psychological assessments, educational programmes)