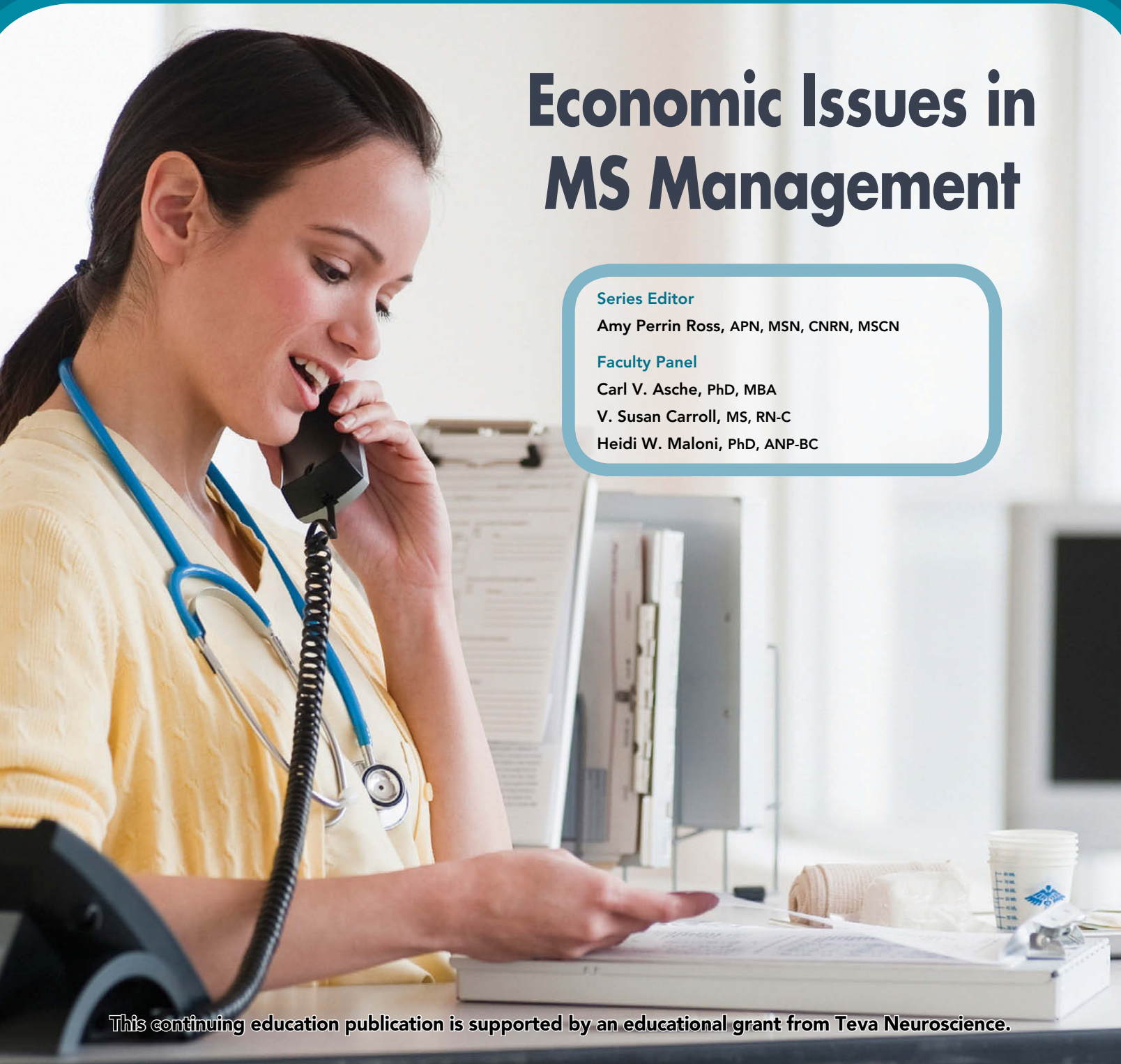


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Counseling Points™

Enhancing Patient Communication for the MS Nurse



Economic Issues in MS Management

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Counseling Points™

Economic Issues in MS Management

Continuing Education Information

Target Audience

This educational activity is designed to meet the needs of nurses who treat patients with multiple sclerosis (MS).

Purpose

To inform MS nurses about the key economic issues in MS and how to advocate for patients in obtaining the treatments needed for their care.

Learning Objectives

Upon completion of this educational activity, the participant should be able to:

- Examine the economic factors responsible for the high costs of MS care
- Describe strategies to help patients obtain coverage for MS medications and assistive devices
- Develop interventions to assist patients with MS in addressing employment-related issues
- Analyze the impact of current health care reform on the management of MS

Continuing Education Credit

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welcome

Dear Colleague,

Multiple sclerosis (MS) nursing has always been multifaceted, with nurses assuming many roles in patient care. These roles include direct clinical practice, education, research, case management, and advocacy. As MS nurses, we are expected to wear all of these hats with aplomb and balance. Most of us are pulled in multiple directions and, all too frequently, one “hat” dominates more than the others. In particular, advocacy on behalf of our patients is rapidly rising to the top of our to-do lists, with increasing amounts of time spent on nonclinical matters. These responsibilities include negotiating with various organizations to arrange financial coverage for MS medications and therapies. On a daily basis, nurses confront an obstacle course of authorizations, preauthorizations, denials, and negotiations with case managers. As the economic health care landscape continues to shift and evolve, we have to take into account not only what is clinically best for the patient, but also real-life factors involved in prescribing a given intervention—cost, availability, and insurance coverage.

Education remains insufficient in preparing nurses for the advocacy role. Advocacy support is available from many organizations, but may be difficult to pinpoint and implement.

The expert faculty panel assembled for this issue addresses the economic aspects of MS and how they affect nurses both in the community and in MS centers. We focus on the challenges facing nurses who are struggling with economic limitations on optimal patient care and place these challenges in broader perspective. We hope this information and the resources provided will be helpful in your practice.



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Economic Issues in MS Management

Health economics and outcomes research is an area of growing interest in this country, as we strive to maintain quality health care delivery while controlling costs. In the field of multiple sclerosis (MS), pharmacoeconomic concepts are emerging, but they may not be as well developed as they are in other fields of medicine (such as cardiovascular disease or diabetes), where managed care has long been an influence. A number of factors specific to this disease contribute to the difficulties in identifying and implementing cost-effective management protocols in MS. One is the growing armamentarium of new and increasingly sophisticated diagnostic and treatment approaches. Health care reform measures, if implemented, have the potential to affect many components of MS care, including treatment options, insurance coverage, and available facilities. These economic factors contribute to the increasing responsibilities that MS nurses encounter.

Economic Burden of MS

MS is an extremely expensive condition. When the disease is left untreated, the mean estimated total lifetime cost per patient is a staggering \$2.4 million.¹ MS is estimated to cost the United States \$28 billion annually in medical costs and lost productivity.² A recent pharmacoeconomic study by Asche and colleagues on the direct treatment costs of MS in the first year of diagnosis compared data from 1,411 people with MS with that of 7,055 healthy controls.³ This study was the first of its kind to use data from a large medical claims database. Total health care costs for MS were \$18,829 versus \$4,038 for controls ($P < 0.001$), including inpatient costs of \$4,110 versus \$836; radiology costs of \$1,693 versus \$259; and pharmacy costs of \$6,151 versus \$817, respectively.³

A study by Pope and colleagues determined the direct all-case medical costs of people with MS in insured populations.⁴ These findings revealed annual insured expenditures of \$7,677 per person with MS versus \$2,394 for other commercially insured enrollees. The authors concluded that those with MS were two to three times more expensive to treat.

There are conflicting findings regarding the breakdown of direct and indirect costs in MS. Some studies suggest that the main driver of MS costs is the high price of disease-modifying therapies (DMTs). For example, analyses of managed care claims have suggested that DMTs account for 65% to 80% of medical costs associated with MS.^{5,6} Among direct costs, treatment of relapse is one of the greatest contributors. In a 2003 study, O'Brien and colleagues estimated the cost of managing one relapse episode in the US.⁷ Utilization of inpatient resources and other associated costs averaged \$12,870 for a "high-level" episode, of which 71% was for inpatient care. Moderate episodes cost \$1,847, while mild episodes cost \$243.

A cross-sectional study by Kobelt and colleagues of patients with MS treated with DMTs found that the greatest cost driver was the indirect costs of missed work time and early retirement.⁸ These researchers demonstrated that medication costs represented only 50% of direct costs in MS and 28% of indirect costs. DMTs actually represented only 21% of total costs (**Figure 1**).

Containing the Rising Costs of MS Care

As the data from Kobelt show, the greater costs of MS lie with *not* treating the disease, rather than with treating it early and effectively.⁸ MS-related costs increase in direct proportion to disease progression and increased disability.¹ One of the most important

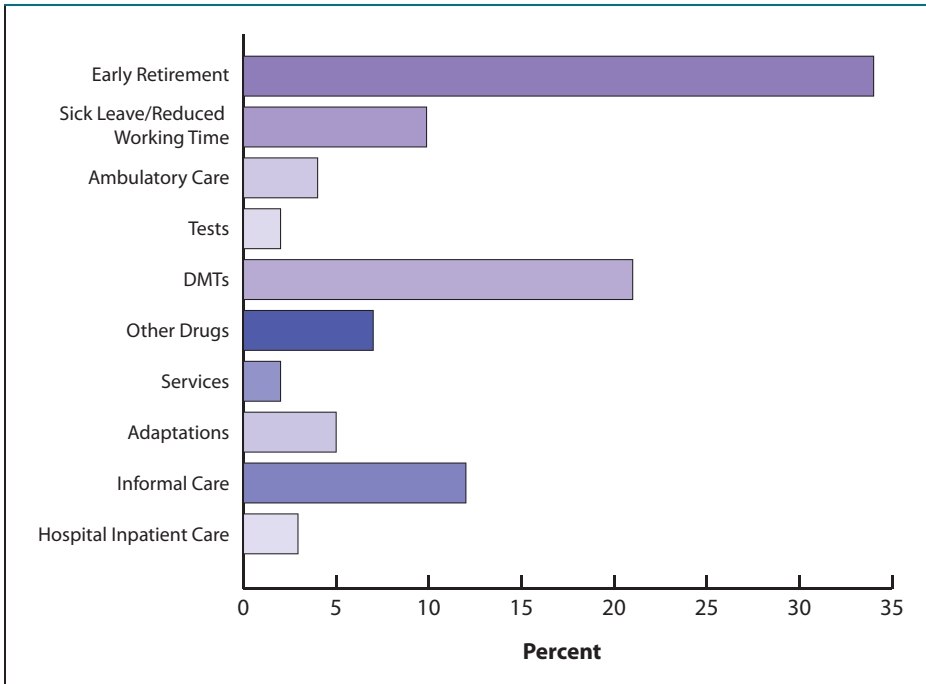


Figure 1. Cost drivers for multiple sclerosis (MS).⁸

DMTs=disease-modifying therapies.

means of reducing MS costs is to intervene at the earliest stages of the disease to delay potential neurologic degeneration. This approach is corroborated by numerous studies establishing that early treatment with DMTs is the best means of arresting or delaying disease progression, thereby decreasing costs further down the line. This recommendation is supported by the National Multiple Sclerosis Society (NMSS) Expert Consensus Statement (**Table 1**).⁹

Managed Care and MS

Managed care organizations (MCOs) seek to reduce the costs of care, often by introducing greater efficiency into health care delivery.¹⁰ One way to do this is by limiting utilization of treatments that are deemed to be less “cost effective” than other treatments.¹¹ However, the complexity of MS throws a number of monkey wrenches into the economic models used to determine which treatments are cost effective.¹² Many important unknowns hamper decision-making from economic, efficacy, and outcomes standpoints, among them:

- MS is not a “one-size-fits-all” disease. Its variable, unpredictable course makes it difficult to develop economically sound treatment protocols that can be applied to broad segments of the population.
- The exact cause of MS is not well understood, so validated preventive initiatives are not relevant.
- It is not understood why some patients with MS have a severe, progressive disease course and others have a slower or even relatively benign course.
- A major shortcoming of our current state of knowledge in MS is how to determine whether patients are responding well to a DMT and

Table 1. Summary of NMSS Expert Consensus Statement on Treatment Recommendations⁹

- Initiate treatment with an interferon beta medication or glatiramer acetate as soon as possible following a definite diagnosis of MS with active, relapsing disease, and consider these treatments for selected patients with a first attack who are at high risk of MS.
- Patients’ access to medication should not be limited by the frequency of relapses, age, or level of disability.
- Treatment is not to be stopped while insurers evaluate for continuing coverage of treatment, as this would put patients at increased risk for recurrent disease activity.
- All FDA-approved agents should be included in formularies and covered by third-party payers so that physicians and patients can determine the most appropriate agent on an individual basis; failure to do so is unethical and discriminatory.
- Therapy is to be continued indefinitely, except when there is clear lack of benefit, intolerable side effects, or a better therapy available.
- Movement from one DMT to another should occur only for medically appropriate reasons.

DMT=disease-modifying therapy; FDA=Food and Drug Administration; MS=multiple sclerosis; NMSS=National Multiple Sclerosis Society.

why some patients respond to particular therapies while others have a poor response. Unfortunately, validated or even consensus definitions of therapeutic failure or “suboptimal response” are lacking.

- How long patients should stay on a DMT is also unclear. A common reason for patients to stop taking a DMT is the perception that the treatment no longer works. How long to keep patients on a particular DMT before stopping or switching therapy is another unresolved question.^{13,14}

Managed care professionals accustomed to applying the “recipe” approach to treatment selection used in cardiovascular medicine or diabetes may not understand the nuances of MS care. Thus, greater education and communication are needed within MCOs to help various parties understand how it differs from other chronic diseases, how to address patients who do not fit into specific patterns, and how to design protocols for MS that make sense within the current state of knowledge about the disease.¹⁵

For decision-makers in MCOs, the task of controlling costs without compromising patient outcomes is daunting. It is particularly difficult where management of MS is concerned.¹⁵ Drug therapies for MS are costly, efficacy is variable and difficult to establish, and therapy dropout and nonadherence rates are high. Instead, decision-makers are being forced to create entirely new models that address “specialty products.”¹⁶ Obsolete models derived from earlier and less-expensive drugs are only partially effective, since generic forms of specialty drugs are not available. This eliminates the economic benefits of robust market competition—i.e., cost savings from generic and therapeutic substitution.¹⁶ The cost of covering these specialty medications is disproportionately high relative to that of other treated populations. For example, the director of a California Medicaid plan stated that less than 1% of plan members receive prescriptions for specialty pharmacy medications (including MS medications), but they

account for 20% of the plan’s drug expenditures.¹⁷

With no immediate relief in sight, MCOs are seeking to rein in coverage of expensive drugs. This is especially true in early disease, when case managers may erroneously assume that it is too soon to initiate treatment with an expensive agent—despite the growing body of evidence pointing to the importance of early intervention in preventing long-term disability.¹¹

Effect of MS Drug Costs on Treatment

Standard DMTs may cost as much as \$40,000 per year.¹⁸ A recent study questioned whether the return on investment is great enough from an economic and quality of life standpoint. Noyes and colleagues used data from a longitudinal MS survey to generate 10-year disease progression paths for an MS cohort, measuring outcomes as gains in quality-adjusted life-years (QALY) and relapse-free years.¹⁹ They found that using a DMT for 10 years resulted in “modest health gains” for all therapies, compared with no DMT (0.082 QALY or <1 quality-adjusted month gain for glatiramer acetate, and 0.126-0.192 QALY gain for interferons). The cost-effectiveness of all DMTs far exceeded \$800,000 per QALY. However, if DMT prices were reduced by approximately 67% (that is, if interferon costs in the United States were equivalent to costs in the United Kingdom), the treatments would stack up as cost-effective.¹⁹

While the findings regarding later initiation of DMTs were mixed, the study did corroborate the growing body of evidence that early intervention is crucial. The researchers emphasized that initiating treatment with DMTs very early in the disease (Expanded Disability Status Scale score of 2 or less) could be more cost-effective than starting treatment later in the disease, perhaps by deferring the substantial costs associated with late-stage MS and disability. In later stages, they concluded, the health gains yielded by DMT use “come at a very high cost.”¹⁹

Most MS nurses have probably encountered cases of patients who drop treatment or cut back on doses because of inadequate or incomplete insurance coverage of their DMT.²⁰ Several studies in multiple therapeutic areas have established that out-of-pocket costs incurred by patients have an impact on adherence.²¹ For example, one study used a database of 2,791 commercially insured individuals with MS who were beginning expensive treatment.²¹ The researchers divided subjects into seven groups, based on their annual out-of-pocket expenses. Adherence decreased inversely with increased expenses (**Figure 2**).

In this study, the most expensive treatments brought the most dramatic increases in nonadherence, while small copayment increases in lower-cost medications had less impact on adherence rates.²² However, other studies of adherence in other illnesses (such as cancer and diabetes) have found that with oral agents, even small copay increases led to poor adherence, with abandonment rates rising with each copay increase.²¹

Meanwhile, managed care must struggle with several questions regarding safety, efficacy, and cost of oral agents for MS, as compared to injectables.²² From the clinician's point of view, the decision to initiate oral therapy in newly diagnosed patients with MS, or to switch a patient from an existing injectable regimen to an oral medication, will be a matter that takes patient preference into account as well as the efficacy and tolerability of the present injectable

regimen, adherence history, and differences in coverage and out-of-pocket expenses.²¹

How Nurses Can Impact Economic Issues in MS

One way in which economic issues affect the MS nurse is in the expanding role for advocacy. Although advocacy has been a component of nursing care for the last four decades, the scope and primacy of advocacy have dramatically increased.²³ Proactive assistance is needed to help many patients obtain the most current therapies.²⁴ Nurses are extremely important in standing up for the patient to obtain DMTs, medical equipment, assistive technologies, services such as physical therapy, and personal attendants.²⁴

Unfortunately, the nurse is often spread thin when it comes to time and resources for handling the financial side of MS care delivery. The amount of time spent in advocacy detracts from the amount of time that could be spent in direct patient care. For this reason, it is important for nurses to learn techniques to maximize their impact and cut down on time involved in advocacy.

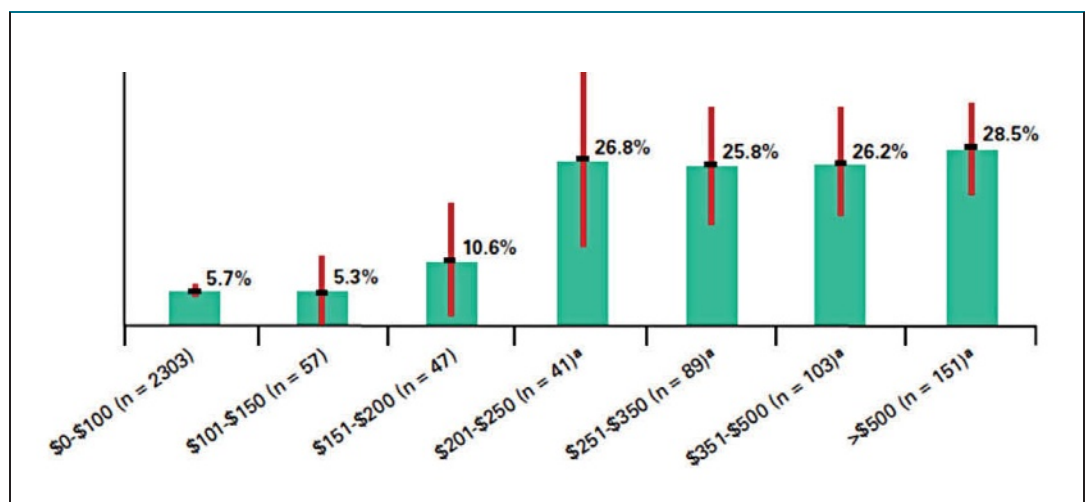


Figure 2. Decreased adherence is associated with higher out-of-pocket expenses for MS medications.²¹

*P<0.001 compared with \$0-\$100 group.

MS=multiple sclerosis.

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Educating Case Managers at MCOs

It is important to understand the dynamics behind an MCO's decision regarding the tier of a given medication. Often, MCOs have complex contractual arrangements designed to provide them with a particular group of medications at a lower rate and place these lower-cost agents in the preferred category or tier. A patient who has been taking a particular drug successfully may suddenly be required to switch to another agent because the MCO is no longer receiving the same financial arrangement as before. In the eyes of the case manager at the MCO, these therapies might be relatively interchangeable, and he/she might not understand why the nurse is campaigning for the patient to be kept on the original regimen. For this reason, an important role for the nurse is educating the case manager. While it may be hard for an individual nurse to influence the decisions of a large MCO, as a group, MS health care professionals can push to have a greater voice within these organizations and influence decision-making based on clinical and scientific knowledge about the disease.

On a one-on-one level, the MS nurse may be in a position to argue specific cases with MCO case managers, who may require and welcome more information about the rationale for different MS therapies.²⁵ An important focus in educating case managers concerns the concept of being “penny wise and pound foolish.” Many MCOs place caps on treatments, limiting the allowable spending for any given patient. It may be necessary for the nurse, as the patient advocate, to emphasize how cutting costs at the front end of treatment can lead to increased costs further down the line.

Strength in Numbers: Multidisciplinary Advocacy

While nurses are often at the forefront of MS advocacy, they are not the only professionals working in

MS and should not be the only advocates. Physicians, rehabilitation therapists, and social workers are among the professionals who play a significant role in patient advocacy.²⁶ Pharmacists can also play a part in education and advocacy. Integrating pharmacists into a medical care team with physicians and nurses has been shown to facilitate positive patient outcomes by improving team drug therapy decision-making, continuity of care, and patient safety.²⁷

Foundations and Professional Organizations

The field of MS care is rich with passionate individuals who have teamed up to form organizations that advocate for people with this disease. According to the Consortium of Multiple Sclerosis Centers' (CMSC) white paper, *Advocacy in MS*, key among these is the nine-organization powerhouse known as the MS Coalition (www.multiplesclerosiscoalition.org).²⁶ Among the goals of this collaboration are to “ensure support and funding for MS research, programs, and awareness” and to “seek to ensure that affordable, comprehensive healthcare and therapies are available to all patients.” By banding together, the unified approach achieves a greater impact on public policy initiatives than these organizations could achieve individually (**Table 2**).²⁶

Keeping Current

One function of these organizations is to provide information to help keep practitioners current with economic, political, and therapeutic developments. Fortunately, there are several resources available to find out about updates such as copays, coinsurances, patient assistance, and legislation that might have an impact on MS patient care. Some suggested resources are listed in **Table 3**.

Manufacturer Assistance Programs and State Prescription Assistance

Many pharmaceutical companies have prescription assistance programs for qualifying patients. Several

Table 2. MS Coalition Members²⁶

- Consortium of Multiple Sclerosis Centers (CMSC)
- International Organization of Multiple Sclerosis Nurses (IOMSN)
- Accelerated Cure Project For Multiple Sclerosis,
- Can Do Multiple Sclerosis
- Multiple Sclerosis Association of America (MSAA)
- Multiple Sclerosis Foundation (MSF)
- National Multiple Sclerosis Society (NMSS)
- United Spinal Association
- The Vision Works Foundation, Inc./MS Friends Initiative

organizations are also available to help patients and providers research prescription assistance programs and help qualifying patients obtain discounted or free medicines (**Table 4**). In addition, many states have prescription assistance programs to help low-income seniors and disabled persons reduce copays on medications. A list of these states, with extensive descriptions of the requirements and benefits, can be found at the websites of the National Conference of State Legislatures.²⁸

Workplace Issues and MS

The unpredictable course of disease and related physical and cognitive impairments associated with MS can lead to difficulties obtaining or retaining employment, or difficulties within the workplace.²⁶ Physical barriers in the workplace and the attitude of employers, professionals, and the community constitute major obstacles for people with MS.²⁴ A 2004 study suggested that, within 5 years of receiving a diagnosis of MS, the majority of patients are unemployed.²⁴ A 2007 study used the North American Research Committee on Multiple Sclerosis (NARCOMS) Registry involving more than 8,000 people with MS to evaluate factors relating to employment. They found that close to 60% of the study population under age 64 (mean age of 47) was unemployed. Over an average period of 18 months, 6% percent of the total sample (12.5% of the employed

sample) became unemployed. Just 3% (5% of those not working) gained employment. As expected, those with worsening symptoms and greater levels of disability were at higher risk for unemployment.²⁹

In the current economic climate, disability is a significant hurdle to employment. Patients are competing with healthy individuals and, despite the Americans with Disabilities Act ostensibly protecting against discrimination, the sad reality is that there is a great deal of discrimination in obtaining and retaining employment.

Nurses can have an impact on the patient's employment-related issues by educating employers and coworkers about the disease—dispelling myths and misconceptions, and helping negotiate workplace accommodations.³⁰ They can also help the patient to negotiate rights and responsibilities under the Family and Medical Leave Act to apply to his or her specific needs.³⁰ In some cases, a goal of the

Table 3. Resources for Economic Information about MS

The Consortium of Multiple Sclerosis Centers (CMSC)	www.msca.org
International Organization of Multiple Sclerosis Nurses (IOMSN)	www.iomsn.org
National Institutes of Health (NIH)	www.ninds.nih.gov/disorders/multiple_sclerosis/multiple_sclerosis.htm
National Multiple Sclerosis Society (web-based information, plus live assistance)	www.nationalmssociety.org
Multiple Sclerosis Association of America (MSAA)	www.msassociation.org
The Center for Medicare Advocacy (general information about Medicare coverage, with specific FAQ section for patients with MS)	www.medicareadvocacy.org/InfoByTopic/ChronicConditions/MS.Main.htm

FAQ=frequently asked questions; MS=multiple sclerosis.

Accountable Care Organizations: How They Affect MS Nurses

Among the components of President Barack Obama's health reform plan (the Affordable Care Act) is the implementation of Accountable Care Organizations (ACOs). This plan is designed to address fragmentation of care, reduce costs, and improve quality in the Medicare Shared Savings Program. ACOs have been defined as follows:

“Collaborations that integrate groups of providers, such as physicians (particularly primary care physicians), hospitals, and others around the ability to receive shared-saving bonuses from a payer by achieving measured quality targets and demonstrating real reductions in overall spending growth for a defined population of patients.”¹

In a press release issued by the Department of Health and Human Services, ACOs are defined as “a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients....The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries.”²

The emphasis of an ACO is to encourage collaboration between professionals within a system, and between systems within a broader organization. The providers (individual practitioners, groups, or institutions) bring all of their patients from a defined population to the ACO. Importantly, it is assumed that members of the ACO will refer patients to one another—either by admitting to the same hospital or “sister” institution, or by referring to a common set of specialists or facilities.¹

One of the reasons providers are motivated to participate in ACOs is to share in cost-savings. However, this might have an impact on local market competition and whether disparate local interests (including primary care physicians, specialists, hospitals, payers, institutions, facilities, and home health care agencies) can work together.³ Another serious concern is that institutions within an ACO (such as hospitals) may have little incentive to assist institutions within other ACOs or to make referrals to independent providers or “competing” institutions.¹ According to a recent report by the Attorney General of Massachusetts, “A key question to answer in any informed discussion of Accountable Care Organizations is how to balance the competing goals of consumer choice and effective clinical and financial management of care.”⁴

For MS nurses, the creation of ACOs increases pressure to refer patients to providers and facilities within a given organization, potentially compromising patient care if the organization is not the best one to meet the patient's needs. It is important to be vigilant and keep the patient's needs paramount.

On the other hand, there are advantages to the ACO concept. It provides an opportunity to expand the skills and role of nurses in a given facility, so that services ordinarily outsourced to other facilities (e.g., infusions) can be provided in-house. This augments the role of nurses and their value to practices in an array of settings, including settings that currently do not have a nurse. From a patient point of view, the expanded role of nurses adds to the continuity of care.

One disadvantage of the proposed Affordable Care Act is that the central providers are physicians, rather than nurses or nurse practitioners (NPs). In fact, six NP organizations wrote a letter to the Administrator of the Centers for Medicare and Medicaid Services objecting to the decentralization of NPs in ACOs. They wrote: “The proposed provisions impose requirements that fail to recognize the education and experience of nurse practitioners in clinical care management, quality assurance, process improvement, and measuring clinical or service performance to improve patient care.”⁵

It remains to be seen what role nurses and NPs will play in ACOs, how much autonomy they will have, and what impact this will have on the care of people with MS.

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Table 4. Information about Prescription Assistance Programs

General Prescription Assistance

Partnership for Prescription Assistance: <http://www.pparx.org/en>

Free Medicine Program: <http://freemedicineprogram.org/>

MS-specific Medications

Avonex® Tysabri®	Biogen Idec	Financial assistance program for patients using Avonex or Tysabri www.Avonex.com www.Tysabri.com 800-456-2255
Betaseron®	Bayer Healthcare	Financial assistance program for those unable to gain access to therapy www.betaseron.com 800-788-1467
Copaxone®	Teva Neuroscience	Copay or medication assistance program; Assistance for Medicare Part D www.sharesolutions.com 800-887-8100
Rebif®	EMD Serono and Pfizer, Inc.	New patients on Rebif therapy or those restarting Rebif therapy Patients covered under Medicare Part D or with private or no insurance www.mslifelines.com 877-44-REBIF (877-447-3243).
Extavia®	Novartis Pharmaceuticals	Patients who cannot afford Extavia treatment and with no private or public insurance coverage www.Extavia.com 866-EXTAVIA (398-2842)
Gilenya®	Novartis Pharmaceuticals	www.Gilenya.com 800-277-2254

nurse may be encouraging patients to remain in the workplace as long as possible, or to return to work if they have taken a medical leave.

Impact of Health Care Reform: What does the Future Hold for MS?

People living with MS and other chronic diseases are especially vulnerable to the fluctuations of health care reform, as politicians and lawmakers pass and then dispute new regulations and requirements. Nurses, acting as advocates for their patients, are in an ideal position to affect public policy as it relates to health care.²⁰ Potential strategies include direct contact with politicians and lawmakers (in-person meetings with elected officials), indirect contact (via e-mail or phone), and other means of publicizing and addressing concerns (through publications,

the web, and social media). According to Bethany Hall-Long, a nurse currently serving as a Senator from Delaware, sharing research data and contributing time or donations to political officials who are friendly toward those with disabilities are also important forms of advocacy.²⁰

Being aware of how health care reform will affect people with MS is key to the advocacy role. For example, one of the proposed legislations would cap out-of-pocket costs at \$200 per month for a single prescription and \$500 per month for multiple prescriptions.²⁰ These changes would apply to all health insurance plans, including Medicare and private market plans. Without this legislation, insurers will continue to move expensive medications such as DMTs to specialty tiers, making them cost prohibitive.²⁰

Conclusion

For nurses, tackling the tough economic issues that affect MS care involves becoming familiar with a complex array of nonclinical issues. This path is challenging and demands the mastery of a new set of skills for the benefit of patients. The course will change as new therapies are approved for patients with MS, as MCOs respond to these new developments, and as the story of health care reform continues to evolve. Keeping updated, utilizing available resources, and collaborating with other professionals on advocacy efforts are important ways for MS nurses to help bring about positive patient outcomes.

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CP Counseling Points™

Economic Issues in MS Management

- Aggressive intervention with disease-modifying therapies (DMTs) in early multiple sclerosis (MS) is a cornerstone in delaying disability and its associated costs later in the course of the disease.
- The National Multiple Sclerosis Society Expert Consensus Statement on Treatment Recommendations for MS emphasize the importance of continuing successful treatment with DMTs, even if insurers have not yet reached a determination regarding coverage of these treatments, and not discontinuing treatment for any nonmedical reasons.
- Patient nonadherence to medication regimens is associated with high out-of-pocket costs of medications.
- Nurses play an extremely important role in advocating on behalf of patients with MS in obtaining DMTs, medical equipment, assistive technologies, or personal attendants. Advocacy includes direct negotiation with the patient's insurer and with the pharmaceutical company's prescription assistance program.
- Nurses should not engage in advocacy in a vacuum. Advocacy is optimally accomplished in consonance with the patient's other health care providers.
- Nurses can play an important role in influencing public policy as it relates to health care via direct contact with politicians and lawmakers, indirect contact (via e-mail or phone), and through nursing and medical organizations and social media.
- Nurses can have an impact on the patient's employment-related issues by educating employers and coworkers about the disease—dispelling myths and misconceptions, and helping negotiate workplace accommodations. They can also help the patient to negotiate rights and responsibilities under the Family and Medical Leave Act (FMLA).

Counseling Points™

Economic Issues in MS Management

Continuing Education Posttest

To receive contact hours, please read the program in its entirety, answer the following posttest questions, and complete the program evaluation. A certificate will be awarded for a score of 80% (9 correct) or better. A certificate will be mailed within 4 to 6 weeks. There is no charge for the CNE credit.

By Mail: Delaware Media Group, 66 S. Maple Ave., Ridgewood, NJ 07450

By Fax: (201) 612-8282

Via the Web: Applicants can access this program at the International Organization of MS Nurses' website, www.IOMSN.org. Click on *Counseling Points* and follow the instructions to complete the online posttest and application forms.

PLEASE SELECT THE BEST ANSWER

1. Lifetime costs of untreated multiple sclerosis (MS) have been estimated at:

- A. \$240,000
- B. \$500,000
- C. \$1.2 million
- D. \$2.4 million

2. According to Kobelt, the factor that most accounts for the high cost associated with MS is:

- A. the cost of disease-modifying therapies (DMTs)
- B. retirement and missed work time
- C. assistive devices
- D. caregiver burden

3. The following are part of the Expert Consensus Statement from the National Multiple Sclerosis Society, EXCEPT:

- A. access to medication should not be limited by relapse frequency
- B. treatment should not be discontinued while insurers evaluate appropriateness of coverage
- C. formularies may limit selection of DMTs to specific drugs among the FDA approved agents.
- D. switching between DMTs should not occur except for medically appropriate reasons.

4. Standard pharmacoeconomic models used in other chronic disease states apply well to MS care.

- A. True
- B. False

5. In a study by Noyes and colleagues, DMTs in MS were found to be:

- A. cost-effective in quality-adjusted life years only if DMT prices were significantly dropped
- B. cost-effective in quality-adjusted life years for some but not all of the standard DMTs
- C. cost-effective for both long-term care and early disease management
- D. cost-effective for long-term care only

6. Studies in MS and other conditions have shown that out-of-pocket costs:

- A. do not significantly impact patient adherence
- B. reduce patient adherence even with low-cost agents

- C. reduce patient adherence mainly with high-priced agents
- D. increase adherence because patients will take what they pay for

7. An important role for nurses is to educate managed care case managers regarding:

- A. the rationale for selection of a given medication
- B. the cost-effectiveness of early intervention
- C. patient history
- D. all of the above

8. When advocating for the patient on economic issues, the nurse should act independently.

- A. True, the nurse is the key advocate for the patient
- B. False, other members of the health care team are key to effective advocacy

9. The nine-organization group leading patient advocacy concerns in MS is called:

- A. MS Collaboration for Quality Care
- B. MS Coalition
- C. MS Cares
- D. none of the above

10. Which legislation protects the rights of people with MS in the workplace?

- A. Family and Medical Leave Act
- B. Accountable Care Act
- C. Affordable Care Act
- D. None of the above

11. Prescription assistance may be obtained through:

- A. cities
- B. counties
- C. states
- D. none of the above

12. What types of facilities are considered appropriate referrals for participants in an Accountable Care Organization (ACO)?

- A. Any facility within the local community
- B. A facility within the ACO
- C. Those listed by the ACO as preferred providers
- D. There is no connection between an ACO and referrals

Counseling Points™: Program Evaluation Form

Economic Issues in MS Management

Using the scale provided (Strongly Agree = 5 and Strongly Disagree = 1) please complete the program evaluation so that we may continue to provide you with high-quality educational programming. Please fax this form to **(201) 612-8282** or complete it online as instructed below.

5 = Strongly Agree 4 = Agree 3 = Neutral 2 = Disagree 1 = Strongly Disagree

At the end of this program, I was able to: *(Please circle the appropriate number on the scale.)*

- 1) Examine the economic factors responsible for the high costs of MS care 5 4 3 2 1
- 2) Describe strategies to help patients obtain coverage for MS medications and assistive devices 5 4 3 2 1
- 3) Develop interventions to assist patients with MS in addressing employment-related issues 5 4 3 2 1
- 4) Analyze the impact of current health care reform on the management of MS 5 4 3 2 1

To what extent was the content:

- 5) Well-organized and clearly presented 5 4 3 2 1
- 6) Current and relevant to your area of professional interest 5 4 3 2 1
- 7) Free of commercial bias 5 4 3 2 1
- 8) Clear in providing disclosure information 5 4 3 2 1

General Comments

9) As a result of this continuing education activity (check only one):

- I will modify my practice. (If you checked this box, how do you plan to modify your practice?) _____
- I will wait for more information before modifying my practice.
- The program reinforces my current practice.

Suggestions for future topics/additional comments: _____

Follow-up

As part of our continuous quality-improvement effort, we conduct postactivity follow-up surveys to assess the impact of our educational interventions on professional practice. Please check one:

- Yes, I would be interested in participating in a follow-up survey.
- No, I would not be interested in participating in a follow-up survey.

There is no fee for this educational activity.

Posttest Answer Key	1	2	3	4	5	6	7	8	9	10	11	12

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