INCREASING Our Value TO CANADIANS

CFP Pharmacy Forum Conference
November 21, 2017

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The Canadian Foundation for Pharmacy sincerely thanks this year’s speakers for their candid insights at the 2017 Pharmacy Forum:

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<thead>
<tr>
<th>Name</th>
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<tr>
<td><strong>Marshall Moleschi</strong></td>
<td>(moderator) Former Registrar, Ontario College of Pharmacists and former Registrar, College of Pharmacists of B.C.; Past-President, Canadian Foundation for Pharmacy</td>
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<tr>
<td><strong>Jim Kirby</strong></td>
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<td><strong>Joe Moose</strong></td>
<td>Owner, Moose Pharmacy, North Carolina</td>
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<td><strong>Catherine Hunter</strong></td>
<td>Partner, PwC, and leader of PwC’s Health Services Consulting Practice</td>
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<td><strong>Elliott Sogol</strong></td>
<td>Senior Vice-President Strategy, Pharmacy Quality Solutions</td>
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PLATINUM

GOLD

SILVER

BRONZE
## Agenda

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<td>7:30 – 8:30</td>
<td><strong>Registration, Continental Breakfast</strong></td>
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<td><strong>Welcome and Introduction</strong></td>
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<td>Dayle Acorn – Executive Director, CFP</td>
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<td>Moderator, Marshall Moleschi</td>
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<td>8:55 – 9:30</td>
<td><strong>The Evidence for Pharmacy Value</strong></td>
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<td>Dr. Lisa Dolovich – Ontario College of Pharmacists Professor in Pharmacy Practice, Leslie Dan Faculty of Pharmacy, University of Toronto</td>
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<td>9:30 – 10:50</td>
<td><strong>The Shift from Distribution to Outcomes: Value-Based Pharmacy in the US</strong></td>
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<td>Elliott Sogol – Senior Vice President Strategy, Pharmacy Quality Solutions</td>
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<td>Joe Moose – Independent Pharmacist Owner, Moose Pharmacies, North Carolina</td>
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<td>10:50 – 11:15</td>
<td><strong>Refreshment Break</strong></td>
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<td>11:15 – 11:45</td>
<td><strong>Value-Based Pharmacy in the US: Panel Q&amp;A</strong></td>
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<td>11:45 - 12:20</td>
<td><strong>Value Based Pharmacy in Canada</strong></td>
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<td>Leila Mandlsohn – Pharmacy Strategy Consultant, Green Shield Canada</td>
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<td>12:20 – 1:10</td>
<td><strong>Lunch</strong></td>
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<td>1:10 – 2:20</td>
<td><strong>Canadian Pharmacy in Transition</strong></td>
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<td>Panel Q&amp;A</td>
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<td>2:20 – 3:00</td>
<td><strong>Where is Health Care Going?</strong></td>
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<td>Catherine Hunter – Partner, National Health Care Consulting Leader, PwC Canada</td>
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<td><strong>Wrap up</strong></td>
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<td>Marshall Moleschi</td>
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<td><strong>Break</strong></td>
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Summary of Key Takeaway Messages

- Pharmacy should not wait for more clinical evidence before developing new payment models.
- Pharmacy research needs to move from micro-measurement of services to outcomes-based research that evaluates pharmacists’ interventions within the broader healthcare system.
- The goal of research is not to measure the value of pharmacy, but the value of improved medication use throughout the healthcare system.
- Pharmacy-level documentation needs to evolve so it can easily be shared with patients and other healthcare professionals.
- The principles of value-based pharmacy are worth pursuing. The key is for pharmacy to sit down with payers before they determine payment models.
- Standardized national performance measures are essential, to circumvent different sets of measures from different payers. Transparency of payment terms is also critical.
- Payment models should reward high performers with bonus payments, rather than penalize those that do not achieve target metrics.
- Medication synchronization lays the foundation for efficiencies in workflow and operations, and sets the stage for an appointment-based model of practice, for expanded services.
- Green Shield Canada (GSC) developed its value-based pharmacy program as an alternative strategy to clients’ growing calls for cost-cutting measures such as capped dispensing fees.
- GSC hired Pharmacy Quality Solutions in the U.S. because it is an established provider of performance measurement services and uses standardized performance measures from an independent, non-profit organization (Pharmacy Quality Alliance). It opted to go this route rather than create a proprietary program or await the development of a Canadian system.
- Pharmacies with GSC plan members are receiving Patient-Impact Scoreboards regarding: adherence rates for hypertension, cholesterol and diabetes drugs; three measures related to chronic disease management; high-risk medication use in the elderly; and enrollment levels in GSC’s Pharmacist Health Coaching Cardiovascular program.
- GSC will begin paying pharmacies based on their scores some time in 2019. GSC has indicated its intent is to reward high-performing pharmacies.
- Canadian pharmacy associations appear to be leaning toward Canada-specific metrics to measure performance, rather than a straight adoption of U.S. metrics.
- Pharmacists need more education about value-based pharmacy and how it can be implemented to advance their practice in the interest of patient care.
- Value-based pharmacy is in very early days in Canada and pharmacy leaders have the opportunity to be proactive to ensure the profession steers this important evolution in professional practice and reimbursement models.
- Attendees at CFP’s Pharmacy Forum in November 2017 were cautiously supportive of a value-based payment system for pharmacy, based on real-time text polling.
ARTICLES FROM WEB SITE (www.cfpnet.ca)

Article 1 (overview)
Putting value to the test

Value-based payment is coming to pharmacy in Canada—and while pharmacy leaders agree that the concept is good, the devil is very much in the details. At the Canadian Foundation for Pharmacy’s 2017 Pharmacy Forum in Toronto on November 21, pharmacists from the U.S. shared their learnings under a value-based care system, and urged pharmacy groups to take immediate steps to ensure they are part of decision-making with private and public payers.

Green Shield Canada (GSC) has already put the ball in motion with the launch of its Value-Based Pharmacy (VBP) program in October. The program is rolling out in three stages, and its impact on pharmacy reimbursement levels will not take effect until sometime in 2019. “The end goal is to improve patients’ health by rewarding pharmacies that provide high quality care, and we are committed to working with pharmacy groups to do that,” said Leila Mandlsohn, Pharmacy Strategy Consultant at GSC.

While the Forum’s panel of representatives for Canadian pharmacy groups listed a number of concerns about GSC’s program, they acknowledged that the insurer has opened a window of opportunity for pharmacy to take leadership before other payers develop similar but separate programs. “We applaud Green Shield for taking the bull by the horns and serving as a catalyst for action. We accept the challenge,” said Perry Eisenschmid, CEO of Canadian Pharmacists Association.

GSC has partnered with Pharmacy Quality Solutions (PQS) in the U.S., a provider of performance measurement services for public and private payers and pharmacies. PQS is a licensed user of the standardized, nationally adopted performance measures developed by Pharmacy Quality Alliance (PQA), a non-profit organization established in 2006 and prompted by the federal government’s new Medicare Part D prescription drug plan. Private payers have since also adopted PQA’s measures through vendors such as PQS.

“PQA is a neutral intermediary between pharmacy and the payer. This is not GSC creating the measures. This is a process that has been in place for a number of years,” said Mandlsohn.

The Forum’s Canadian panelists put forward the possibility of a made-in-Canada version of PQA, one that could also draw upon features from other countries’ performance-measurement systems. Another option is for Canadian pharmacy groups to join PQA with the aim to develop Canada-specific metrics.

One of the U.S. speakers, however, cautioned against spending too much time debating the current metrics. While refill rates may not tell the full story about adherence levels, for

“The end goal is to improve patients’ health by rewarding pharmacies that provide high quality care.”
Leila Mandlsohn, Green Shield Canada
example, they can be captured through claims data and serve as a starting point. “It may not be best for the patient or the provider, but we have to start somewhere,” said Joe Moose, co-owner of six Moose Pharmacy stores in North Carolina. The bigger priority, especially since Canada is still in early days, is “to sit down with [the payers] who are making the rules. You want to make sure that if they take away money, they do that to the non-performers. And then they pay more to those who are high performers.”

All three of the U.S. pharmacies represented at the Forum—representing a large chain (Kroger), a large banner program (McKesson’s Health Mart) and Moose Pharmacy—agreed that the benefits of performance-based payment models outweigh the drawbacks. “Value-based care is here to stay and in the end it’s better for patients and it’s helping us be better at what we do,” said Jim Kirby, Senior Director of Pharmacy Services at Kroger.

“We are really being challenged to shift our business model from distribution to patient-centric, performance-based care,” noted Crystal Lennartz, Chief Pharmacist for Health Mart, McKesson Corporation. She added that medication synchronization within an appointment-based model of practice is a key part of the transition. “Medication synchronization is the closest thing we have to a silver bullet. We have increased adherence, decreased gaps in care and created more time for other patient services.”

**Articde 2**

**Time to shift course on pharmacy research**

*Presented by Dr. Lisa Dolovich, Ontario College of Pharmacists Professor in Pharmacy Practice, Leslie Dan Faculty of Pharmacy, University of Toronto*

Pharmacy has done a commendable job in using clinical practice research to demonstrate the value of what pharmacists do in the healthcare system. But the data can only go so far in showing pharmacists’ worth day to day in contributing to better patient outcomes. That was the message relayed by speaker Lisa Dolovich, the Ontario College of Pharmacists Professor in Pharmacy Practice at the University of Toronto’s Leslie Dan Faculty of Pharmacy, and an executive member of the Ontario Pharmacy Evidence Network.

“Health is a constellation and expecting that one medication change by pharmacists will affect everything else down the road is unrealistic,” said Dolovich. Instead it’s about how pharmacists integrate into the overall system to bring those best outcomes to patients who will have the greatest impact.

While pharmacy should be proud of initiatives like the Ontario Cardiovascular Health Awareness program—which demonstrated how pharmacists can help increase the use of hypertensives and reduce hospitalizations—Dolovich said there is need for many more such
initiatives. “On one hand we have improvements on specific things but when you take it further to how pharmacy impacts patients, we’re a little less certain,” she said. “The evidence is mixed and we need to recognize this.”

Rather than stay on the path of micro-measurement of whether a particular pharmacy service is delivered, Dolovich said that pharmacy needs to get outside of the rest of the healthcare system, which means truly understanding the contribution pharmacists can make as part of a system of healthcare professionals. “We have to also consider that while we want to be part of the team, we’re not the centre of the system—only the patient is,” she said. “We need a lot of components for learning the healthcare system, including the participation of patients and their families.”

Dolovich also suggested that documentation evolve so it can easily be shared with patients and healthcare professionals. “Imagine a world where all the recommendations pharmacists make are explicitly documented and available to patients, so they can really see what you do,” she said. “What a powerful voice that would be for patients to have.”

Dolovich told the audience that it’s high time pharmacy—and the entire healthcare system—shifts from volume to value. “We have to measure health outcomes and costs and use that to improve care delivery and reward high-value care,” she said.

**Key takeaways**

- Pharmacy should not wait for more clinical evidence before developing new payment models for pharmacy.
- Pharmacy research needs to move from micro-measurement of services to outcomes-based research that evaluates pharmacists’ interventions within the broader healthcare system.
- The goal of research is not to measure the value of pharmacy, but the value of improved medication use throughout the healthcare system.
- Pharmacy-level documentation needs to evolve so it can easily be shared with patients and other healthcare professionals.

"Imagine a world where all the recommendations pharmacists make are explicitly documented and available to patients, so they can really see what you do.”

Lisa Dolovich, University of Toronto & OPEN

**Article 3**

**Value-based care can be better care**

*Presented by U.S. panel: Elliott Sogol, Senior Vice-President, Strategy, Pharmacy Quality Solutions; Crystal Lennartz, Chief Pharmacist, Health Mart, McKesson; Jim Kirby, Senior Director, Pharmacy Services, Kroger; Joe Moose, Pharmacist and Co-Owner, Moose Pharmacy*

Profitability is not the only “bottom line” affected by a value-based pharmacy (VBP) payment system. Patient care can also be impacted—and for the better, according to U.S. panelists at
The CFP’s Pharmacy Forum in November 2017. The U.S. pharmacists shared their experiences with VBP—also referred to as value-based payment or pharmacy-based care—to help Canadian pharmacy retailers and associations prepare for its likely emergence here, beginning with the launch of Green Shield Canada’s program in October 2017.

In the U.S., the federal government began implementing value-based reimbursement programs for health plans more than 10 years ago, as part of sweeping healthcare reforms. Pharmacies’ performance scores contribute approximately 50% to a plan’s overall score (with physicians and hospitals contributing the rest). In 2006, the government created the Medicare Part D prescription drug plan for citizens aged 65 and older, which put even more focus on pharmacies’ performances and led to additional pharmacy-only value-based programs.

In the U.S., it’s estimated that about half of all Medicare Part D claims are attached to a value-based payment model. In recent years, commercial plans began adopting VBP. It’s too soon to know the numbers, but all four of the U.S. panelists expect VBP to steadily accelerate in the U.S. Controversy is also growing, as pharmacies and pharmacy advocacy bodies push back against U.S. pharmacy benefit managers that use VBP as a cost-containment measure, by financially penalizing pharmacies that score below certain levels in addition to (or instead of) rewarding the top-performers.

Yet, despite the controversies caused by payers, the U.S. speakers stressed that VBP is in fact better for patient care.

“Value-based care is here to stay and in the end it’s better for patients and it’s helping us be better at what we do,” said Jim Kirby, Senior Director of Pharmacy Services at Kroger. Added Crystal Lennartz, Chief Pharmacist for Health Mart, McKesson Corporation: “We are really being challenged to shift our business model from distribution to patient-centric, performance-based care.”

“We need to think of value-based payment models as just a new term for patient-centered care,” echoed Elliott Sogol, Senior Vice President, Strategy, for Pharmacy Quality Solutions, who also spoke on behalf of the American Pharmacists Association.

In fact, when done right by insurers and pharmacies, value-based payment or value-based care is good for both profitability and patient care. “If you’re a five-star pharmacy then you will get
more reimbursement,” said Joe Moose, co-owner of Moose Pharmacy in North Carolina, adding that the model can work especially well for complex patients.

Having said that, the U.S. panelists also agreed it is a long road to realize the benefits for both patients and pharmacies and, south of the border at least, not all value-based payment contracts are created equal. Some contain pitfalls that negatively affect pharmacy revenue, despite efforts to meet the metrics for quality care. With this mind, the panelists presented two main missions for Canadian pharmacy associations and individual pharmacies: be part of the development process with insurers, and get your house in order to establish efficiencies in dispensing as well as in the provision of patient services.

**Seat at the table**

While the two countries’ healthcare systems differ significantly, the panelists suggested that Canada can learn from the U.S. experience. First, be proactive. Don’t wait for payers to come to you with their value-based programs. “In Canada you are early in the game. You have to sit down with [the payers] who are making the rules,” said Moose.

During discussions, stick to the common ground for both sides: better quality care means better outcomes for patients and lower costs for payers. With that always in mind, “you want to make sure that if they take away money, they do that to the non-performers [in pharmacy]. And then they pay more to those who are high performers,” summarized Moose.

Standardization and transparency are key. In the U.S., the Pharmacy Quality Alliance, a non-profit organization, has implemented standardized, national medication-based performance measures for pharmacies. Physicians, on the other hand, are faced with measures that do not have standardized specifications for calculations, and as a result “they are pulling their hair out because they have multiple measures that change with payers,” said Sogol.

Transparency of payment terms is especially critical, since final reconciliations happen months after prescriptions are dispensed. In the U.S., disbursements for VBP occur one to three times a year, noted Sogol. Pharmacies and pharmacy associations there are also grappling with pharmacy benefit managers’ growing use of direct and indirect remuneration (DIR) fees. In some cases, pharmacies have to pay a DIR fee to join a plan’s network and their goal is to get that money back by meeting the quality-measure requirements. Ideally a pure bonus is also in place as an incentive, but that’s not always the case.

Long story short, what’s happening in the U.S. underlines “the importance of getting to the table early to frame conversations with payers,” stressed Kirby.

**House in order**
Despite the challenges, all three of the U.S. pharmacy representatives described the strides they are making under a performance-based system. For example, 43% of McKesson’s 4,800 Health Mart pharmacies now score in the top 20% for at least one of the quality metrics, compared to 22% in 2013. “The conversation has really shifted to what do we do to enhance our performance,” said Lennartz.

Efficiency in the dispensary is prerequisite, which includes maximizing the use of technicians, automation and, if volumes warrant, central filling. What kicks performance—including patient care—into high gear, however, are medication synchronization and an appointment-based model of practice. “Medication synchronization is the closest thing we have to a silver bullet,” emphasized Lennartz. “We have optimized work flow, improved inventory management and decreased the cost of dispensing. We have increased patient retention, increased adherence, decreased gaps in care and created more time for other patient services.”

For every patient enrolled in the synchronization program, the pharmacy gets an additional 2.3 prescription fills on average, noted Kirby in his presentation.

Once synchronization is underway, the appointment-based model enables pharmacists to smoothly step into their role as care providers. Each monthly pick-up of medications is an opportunity to sit down with patients and focus on their needs. “We’ve found that every single patient who is synched has at least drug therapy problem. We’ve created a structured protocol with monthly follow-ups when there is a specific need and then quarterly check-ins. Longitudinal interactions are key,” said Kirby.

“True medication synchronization is about connecting with patients and developing and reinforcing a care plan,” stressed Moose. Improved adherence to medications is one of the first positive outcomes, which leads to better scores—and higher levels of remuneration—under value-based payment systems.

**Key takeaways**

- The principles of value-based pharmacy—that is, using performance metrics to help improve outcomes, such as adherence rates for certain drug categories—are worth pursuing for better patient care. The key is to sit down with payers before they determine payment models.
- Standardized national performance measures are essential, to circumvent different sets of measures from different payers.
- Transparency of payment terms is also critical, since final disbursements will occur months after prescriptions are dispenses.
- Payment models should reward high performers with bonus payments, rather than financially penalize those who do not achieve target metrics.
- Medication synchronization lays the foundation for efficiencies in workflow and operations, and sets the stage for an appointment-based model of practice for expanded services.
**Green Shield’s road to value-based pharmacy**

*Presented by Leila Mandlsohn, Pharmacy Strategy Consultant, Green Shield Canada*

When Green Shield Canada (GSC) launched its Value-Based Pharmacy (VBP) program in October 2017, it also launched a lively debate with pharmacy associations and pharmacies. Why did it launch such a program? Will it eventually lead to lower reimbursement levels for pharmacies? What metrics are used to measure the quality of pharmacists’ services? And why hire a U.S. provider?

Leila Mandlsohn, Pharmacy Strategy Consultant at GSC, took to the podium at the Canadian Foundation for Pharmacy’s 2017 Pharmacy Forum to answer these and other questions.

By way of background, she explained that more of the insurer’s clients are asking for cost-containment strategies such as capped fees, capped coverage and the removal of coverage for certain (usually higher-cost) drugs. Rather than encourage clients to go down that road, GSC took a closer look at quality improvement programs being put in place on the public side (for example, Ontario’s Excellent Care for All Act that includes performance-linked compensation models for hospital executives).

“That led us to ask, how can we ensure plan members are getting access to the care they need, and plan sponsors are getting value for what they spend?” said Mandlsohn, who added that “the evidence shows that measuring quality does improve patient outcomes.”

GSC decided to partner with Pharmacy Quality Solutions (PQS) in the U.S., an established provider of performance measurement services for public and private payers and pharmacies, rather than create a proprietary program or work with a Canadian provider that would have had to start from scratch. PQS is a licensed user of the standardized, nationally adopted performance measures developed by Pharmacy Quality Alliance (PQA), a non-profit organization established in 2006 and prompted by the federal government’s new Medicare Part D prescription drug plan. Private payers have since also adopted PQA’s measures through vendors such as PQS.

“PQA is a neutral intermediary between pharmacy and the payer. This is not GSC creating the measures. This is a process that has been in place for a number of years,” said Mandlsohn.
To generate its “Patient-Impact Scorecards” for pharmacies, GSC is using eight metrics, seven of which come directly from PQA:

- Three metrics that track adherence rates for drugs to treat hypertension, cholesterol and diabetes, based on claims data for the “proportion of days covered”;
- Three metrics related to chronic disease management: 1) statin use in persons with diabetes, 2) suboptimal control among people with asthma and 3) the absence of controller therapy among people with asthma; and
- One safety metric specific to high-risk medication use by the elderly.

The eighth metric is specific to GSC and reports on enrollment levels in GSC’s Pharmacist Health Coaching Cardiovascular program.

Why these metrics? “We know that adherence is a major problem, and we know it can be directly impacted by pharmacists,” said Mandlsohn. “They are relatively easy to understand and improve upon, and they are applicable to Canada.” The intent is to identify high-needs patients, and the VBP scorecard is a mechanism to do that. Pharmacies that subscribe to the PQS EQuIPP system can identify individual patients through their prescription numbers.

While the insurer is “open” to a made-in-Canada value-based system and Canada-specific metrics, “we are hoping to see Canadian associations join PQA. We think this is an opportunity to leverage the work already done [in the U.S.],” said Mandlesohn.

GSC is rolling out its VBP program over three years. In year one, GSC is mailing its scorecards to pharmacies and encouraging enrollment in EQuIPP to access more pharmacy-specific reports (note: at the time of the CFP conference, PQS had not yet determined the cost for a Canadian pharmacy to subscribe). In year two (starting late 2018), for pharmacies with a minimum required number of patients with GSC drug plans, the insurer will make scores available to clients and their plan members. “Plan sponsors have asked for that, to help plan members make smarter decisions when seeking services,” noted Mandlsohn.

In year three, GSC will tie reimbursement levels to pharmacy’s scores. “The fundamental goal is not to cut spending. The end goal is to improve patient health by rewarding pharmacies that provide high quality care,” stressed Mandlsohn.

**Key takeaways**

- Green Shield Canada (GSC) began investigating quality-improvement programs in an effort to present an alternative strategy to clients’ growing calls for cost-containment measures such as capped dispensing fees.
- GSC hired Pharmacy Quality Solutions in the U.S. because it is an established provider of performance measurement services and uses standardized performance measures from
an independent, non-profit organization (Pharmacy Quality Alliance). It opted to go this route rather than create a proprietary program or await the development of a Canadian system.

- Pharmacies with GSC plan members are now receiving Patient-Impact Scoreboards regarding: adherence rates for hypertension, cholesterol and diabetes drugs; three measures related to chronic disease management; high-risk medication use in the elderly; and enrollment levels in GSC’s Pharmacist Health Coaching Cardiovascular program.
- GSC will begin paying pharmacies based on their scores some time in 2019. GSC has indicated its intent is to reward high-performing pharmacies.

**Article 5**

**Pharmacy needs to steer value-based practice**

*Canadian panelists: Justin Bates, CEO, Neighbourhood Pharmacy Association of Canada; Perry Eisenschmid, (then) CEO, Canadian Pharmacists Association; Nancy Lum-Wilson, Registrar, Ontario College of Pharmacy; Mike Cavanagh, Pharmacy Owner and Chair, Ontario Pharmacists Association*

A panel of Canadian pharmacy stakeholders weighed in on the inevitable changes that will affect the profession as pharmacy transitions to a more value-based model of care. Speaking at the 2017 Pharmacy Forum hosted by the Canadian Foundation for Pharmacy, the panelists agreed on some key objectives: putting patients at the centre of care and connecting key stakeholders across the healthcare system to collaboratively map out a sustainable future. Here are the highlights:

**Nancy Lum-Wilson** – Calling for a standardized approach to care, she noted that value-based services should be grounded in outcomes. “Our role is always going to be to protect the public and put the patient first,” she said, noting that the pharmacists’ role will only get more prominent as the accountability to patients gets even greater.

“Value-based pharmacy is a great place to begin but we have to look at it from an equity standpoint as well,” she said. Rather than risking inequitable care, or having “20 different insurers paying pharmacists in 20 different ways,” Lum-Wilson said we need a broader approach focused on outcomes rather than drugs. She asked audience members to ask themselves whether they are really putting patients ahead of business goals and enabling access to timely and quality care.

As a regulator, Lum-Wilson said the OCP would continue to focus on pharmacy standards of practice. “When it comes to patients, we believe if you have a code of ethics and get pharmacists to standard all the time, we will have better outcomes.”

Given that change is coming not matter what, Lum-Wilson recommended that it is in in pharmacists’ best interest to “drive the bus.”
Perry Eisenschmid – While the profession shouldn’t be surprised by the change in direction to value-based care, Eisenschmid expressed concern around software costs and other potential pitfalls. “The last thing we need is a private insurer coming up with its own metrics and competing metrics don’t make sense,” he said. “Plus there’s no question that pharmacists have a key role to play, but they don’t control all the factors and that needs to be flushed out.”

Eisenschmid warned against creating measures focused on process rather than outcomes. “Otherwise, there is risk of creating a system that is more punitive than rewarding,” he said. “It’s not a far reach to imagine a world where we are taking money away from pharmacists not performing to key level...and that’s something we need to address.”

He noted CPhA’s willingness to work with stakeholders to create a “made in Canada” pharmacist-led solution, which either builds on existing initiatives or draws from what’s best-in-class globally.

Justin Bates – Bates echoed the need to take an innovative, Canadian-centric approach to rewarding behavior that leads to improved outcomes rather than risk being punitive. “We need to work on this on a pan-Canadian level,” he said. “We need to engage pharmacy and pharmacists—I don’t know how you can do this without pharmacists at the table.”

Bates talked about Neighbourhood Pharmacy’s recent initiatives around modernizing the current reimbursement model from ‘pills to patients.’ “The model has been under threat for a long time and we need to bring together the entire ecosystem to come up with a better model that is about patients,” he said.

Within the next six months, Bates said the association would be conducting a “more robust engagement process” among industry stakeholders to discuss the feedback gleaned so far. “We need a model working with private and public sector that establishes benefits on both sides.”

Mike Cavanagh – As an independent pharmacy owner, Cavanaugh noted that value-based pharmacy is certainly “daunting” but it could also be beneficial in encouraging better pharmacists and pharmacies. “But what is fair metrics and who decides?” he asked, noting that it was a ‘wild west’ out there currently. “I worry that chains would mobilize and implement a system faster, that pushes [independents like] me out.”

To make the system successful, Cavanagh emphasized the need to collaborate with insurers, prescribers, employers and patients. “We need to get the right metrics that are applicable to Canada,” he said. “And as pharmacists we’re going to need support with lots of tools, resources and examples. I’d like to see a road map on how exactly we get there.”

Key takeaways
• Canadian pharmacy associations appear to be leaning toward Canada-specific metrics to measure performance, rather than a straight adoption of U.S. metrics.
• Pharmacists need more education about what value-based pharmacy really means and how it can be implemented to advance their practice in the interest of patient care.
• Value-based pharmacy is in very early days in Canada and pharmacy leaders have the opportunity to be proactive to ensure the profession steers this important evolution in professional practice and reimbursement models.

Article 6
What do Canadian opinion leaders think?
(Audience poll results)

Attendees at the Canadian Foundation for Pharmacy’s annual Pharmacy Forum in November 2017 were cautiously supportive of a value-based payment system for pharmacy, according to real-time text polling conducted by CFP during the event. While the results can be considered directional only, and not statistically valid, they do provide an interesting snapshot of opinions in the room. More than 80 attended the event, mainly representing pharmacists/pharmacy retailers, pharmacy associations and pharmaceutical manufacturers.

• At the start of the event, 67% of attendees agreed that “it’s about time” for value-based pharmacy and it should proceed “full steam ahead.” An additional 18% agreed in principle but wanted to wait and see before acting, and 14% were concerned about the negative impact on pharmacy.
• Interestingly, at the end of the event, attendees appeared to be less confident, as these numbers had shifted to 56%, 15% and 21%, respectively. However, these results may also reflect a smaller response base at the end of the day.
• When asked if they can envision aspects of the U.S. value-based model in Canada, 25% responded “Yes, easily,” while the majority (67%) opted for “Yes, with modifications.”
• 57% agreed that other payers, including the provinces, will move toward outcomes- or value-based reimbursement over the next five years; 43% believe it will come sooner, over the next year (7%) or two years (36%).
• 48% were not sure if pharmacy associations are doing enough to provide information, resources and advocacy around value-based payment, in part because there is a general lack of understanding. 44% would like to see pharmacy associations do more.
• In a question aimed at pharmacists and pharmacy retailers in the room, 53% responded that they will be making adjustments to their practice sites over the next six months to better meet Green Shield Canada’s eight metrics under its Value-Based Pharmacy program.
• 38% of attendees felt Green Shield’s initiative is not consistent with the current regulatory framework in Canada; 38% are not sure and 25% believe it meets regulatory requirements.
Cost pressures, new technologies and changing consumer expectations are shaping the delivery of health care in Canada, and proof of value is increasingly the touchstone for decision-making, summarized Catherine Hunter, Partner at PwC Canada and leader of its Health Services Consulting Practice, at the Canadian Foundation for Pharmacy’s Pharmacy Forum in November 2017.

Hunter highlighted numerous emerging trends, drawing from research conducted by PwC and others. Among them:

- More public- and private-sector collaborations to drive innovation and new business models. For example, federal funding of innovation “clusters” or “hubs” (such as Canada’s AGE-WELL technology and aging network).
- A growing readiness among consumers to access health care from a team of healthcare professionals that extends well beyond physicians.
- Consumers also increasingly desire options for virtual health care. “Through our day-to-day interactions with technology, we’re prepared to access health care in this way as well,” noted Hunter.
- Globally, public payers are putting more focus on value and the rewarding of positive outcomes.
- The “democratization” of health care to improve accessibility. For example, insurance carriers in Canada have launched their own telehealth services for clients’ plan members.

“Consumers are willing to receive health care in new ways,” asserted Hunter. “Pharmacists have the opportunity to be a key delivery mechanism [for healthcare services].” And payers’ growing desire for proof of value—and a budding willingness to incentivize positive outcomes—could bode well for the profession when one considers the many services of value already provided by pharmacists, which are not recognized or reimbursed.
KEY Q&A DISCUSSION POINTS

Evolution of documentation

• If pharmacists do not document their interventions, they didn’t happen; however, there are many logistical challenges, including the fact that many pharmacies still rely on faxes to communicate with physicians.

• There are no easy solutions: documentation needs to become a much greater priority than it is, with new tools and approached with a new mindset, and that must begin with pharmacy owners and pharmacy head offices.

• Documentation must evolve beyond being a checklist for pharmacists; it needs to capture pharmacists’ interventions and recommendations in a way that can be readily shared with patients and other healthcare professionals.

• Equally important, documentation needs to be approached as an untapped goldmine in capturing both quantitative and qualitative outcomes from patients, to help prove the value of pharmacists’ services within the total healthcare system.

Quick look at U.S. payment models

• In the U.S., value-based payment plans can incorporate incentives or bonuses based on a flat rate per capita, or based on a percentile.

• Pharmacies may initially have to pay “direct and indirect remuneration” (DIR) fees upfront, which are partially or fully reimbursed based on performance—and the highest performing pharmacies could receive bonus payments that exceed the upfront DIR fees.

• In a straightforward per capita scenario, for example, the pharmacy could receive $25 per patient per metric over a six-month period (i.e., for patients who are adherent based on stated criteria).

• In a percentile scenario with DIR fees, let’s say that the plan takes $5 off the top per prescription. If the pharmacy’s score for a metric is over the 80th percentile, for

“Nothing that pharmacists document should be for evaluation only. It needs to be done because it’s important clinically and needs to be shared with other healthcare professionals and with patients.”
Lisa Dolovich, University of Toronto, OPEN

“Payers are not saying they need more evidence; they need more help. [They are starting to] see pharmacists as being able to connect with the patients who are costing them a lot of money.”
Joe Moose, Moose Pharmacy

“Yes, you hear the negative stories about clawbacks. But then when you research performance scores, you learn that maybe 50% of their patients are adherent. Is that okay? Whereas you’re not going to hear complaints from the high performers. They are focused on the patient care perspective and perform well on the quality measurements.”
Elliott Sogol, Pharmacy Quality Solutions
example, it gets $6 back (i.e., a $1 bonus). If it is in the 50th to 80th percentile, it gets $3.50 back, and remaining pharmacies get nothing back.

- The American Pharmacists Association is lobbying payers with percentile-based payment systems to implement programs that are net neutral, i.e., where the higher payments for high performers are drawn from the lower payments to low performers, so that the plan’s total payout to pharmacies remains the same.

- Some payment models also assign “risk scores” to patients to safeguard against pharmacists cherry-picking less-complex patients for medication therapy management services. In other words, complex patients deemed to be at higher risk of hospitalization would generate higher bonus payments.

**Don’t get stalled on the metrics**

- The U.S. panel cautioned Canadian pharmacy leaders against spending too much time debating the current metrics, developed by the Pharmacy Quality Alliance (PQA). While refill rates may not tell the full story about adherence levels, for example, they can be captured through claims data and serve as a starting point.

- Instead, pharmacy leaders need to focus on working with the insurance industry to develop payment models that achieve payers’ objectives without putting undue financial hardship on pharmacies.

- PQA is currently working on new measures for pharmacy, particularly regarding services provided to more complex or sicker patients.

**What are PQA and PQS?**

- The Pharmacy Quality Alliance (PQA, www.pqaalliance.org) is non-profit organization established in 2006 at the behest of the U.S. federal government (when it launched its Medicare Part D prescription drug plan). More than 200 researchers, academics, pharmacy associations, community pharmacies, plan sponsors, pharmacy benefit managers, pharmaceutical companies, patient advocacy groups and government agencies are members of PQA, and are part of the process to develop the metrics that are used to rate health plans’ performances based on patient outcomes, including the performances of physicians and pharmacists (by pharmacy).

- In 2017, PQA announced its first Canadian member: the Ontario Pharmacy Evidence Network.

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“The timeline on this is probably shorter than you think. Don’t wait for someone else to figure it out. Also you’re not going to legislate your way out of this. You have to innovate your way out of it.”

Joe Moose, Moose Pharmacy

“When developing metrics, it's super important that you don’t focus on metrics that you want, but that you focus on metrics that payers want. Start with what they need to measure and improve and work with that.”

Joe Moose, Moose Pharmacy
PQA has developed 32 performance measures so far. Many focus on adherence, based on claims data showing the proportion of days covered (PDC) for certain medications. A PDC of 80% is required for patients to be deemed adherent.

In 2018, PQA is expected to release new pharmacy-specific metrics.

Pharmacy Quality Solutions (PQS) is a leading U.S. provider of value-based payment systems for public and private payers. It is a licensed user of PQA’s metrics, and PQA is its majority owner.

PQS created the EQuIPP (Electronic Quality Improvement Platform for Plans & Pharmacies) online platform for health care providers, insurance providers and pharmacy benefits management companies to access and assess performance ratings, using a broad range of reporting tools (pharmacies, for example, can identify “outlier” patients with the lowest adherence rates). According to its website (www.pharmacyquality.com), 95% of U.S. community pharmacies subscribe to EQuIPP.

In 2013, EQuIPP’s database contained records for 1 million patients included in some type of value-based program (i.e., involving pharmacies, physicians or hospitals). By 2017, that had jumped to 20 million. Most are beneficiaries of the U.S. government-administered Medicare and Medicaid plans for seniors and low-income citizens. PQS predicts growth will continue to accelerate as more commercial plans adopt value-based payment systems.

Patients’ perceptions slow to change

Change management applies as much to consumers as it does to pharmacists, noted speakers and members of the audience, and it can take a long time to change people’s perceptions of pharmacists’ capabilities.

While consumers generally already think positively about pharmacists, the profession needs to acknowledge that patient satisfaction is currently more likely linked to convenience rather than services received.

It’s important to market pharmacists’ services in terms of their benefits to patients—don’t just market pharmacists’ expertise.

“Quality-based care is not going anywhere. Get started, even with small steps, for example focusing on refills and medication synchronization.”

Jim Kirby, Kroger

“We’re not as far along in shifting patient perceptions [as we thought we would be]. Just as pharmacists have to go through change management, so too do patients.”

Crystal Lennartz, McKesson

“[Recognize] when it is all too new for them. If a patient says we are calling too much, asking too many questions, we know we have to back off for a bit.”

Joe Moose, Moose Pharmacy