



» Measuring the performance of pharmacies

Last summer we told you about our Value-based Pharmacy initiative – a strategy to drive accountability in our health care system and ensure that our plan members are getting the best possible quality of care. (See the *GSC Update* of July 2017.) The first phase of this initiative focuses on measuring pharmacy performance based on a set of eight measures and provides that information to pharmacies across Canada through monthly Patient-Impact Scorecards.

The eight measures, based on well-established clinical guidelines are divided into three categories: adherence to drug therapy, chronic disease management, and safety of medication use. The scorecards show each pharmacy their own performance score for the measures, a GSC-established goal that we consider attainable (based on performance of higher-performing pharmacies), and a provincial average score to help them understand their performance compared with other pharmacies.

Pharmacies have been receiving scorecards since October 2017, so eight months in, let's examine the data and see how they're doing...

Medication adherence

The adherence measures focus on three common chronic conditions – no surprise that these are hypertension (high blood pressure), high cholesterol, and diabetes. As we've all learned from past GSC Health Studies, these are conditions that have consistently seen poor medication adherence.

Why measure pharmacy performance?

Our overriding goal is to ensure that patients are getting the best quality of care from their pharmacy. The Value-based Pharmacy Initiative focuses on these key objectives:

- Providing performance feedback to facilitate improvement
- Reaching high-needs patients
- Supporting the evolution of pharmacy practice.

Reminder: Medication adherence simply means taking prescribed drugs as directed – the right drug, the right dosage, for the right length of time.

By analyzing GSC claims for certain drugs that treat these chronic conditions, the adherence measure evaluates how well the pharmacy ensures its GSC patients continue to refill the medications regularly and without gaps. The score for each measure indicates the proportion of patients that are highly adherent to their medication (i.e., patient adherence is 80 per cent or higher).

Measure	National average (GSC patients)	GSC target	Notes
Hypertention	82.2%	93.4%	Adherence scores are better when they are higher, meaning more patients are highly adherent to their medication.
Cholesterol	80.6%	92.3%	
Diabetes	79.2%	92%	

Disease management

The disease management measures draw on GSC drug claims data to evaluate how well a pharmacy ensures that patients are getting the best and most appropriate medications to treat their condition. The measures in this category assess whether:

- Patients taking diabetes medications are also taking medications called statins that help prevent a future heart attack or stroke.
- Patients with asthma are using their appropriate medications to keep their condition under control. (Asthma management has two separate measures involving the use of two types of asthma medication: controller therapy and a reliever, or rescue, medication.)
- Patients taking medication for cardiovascular disease are getting health coaching from their pharmacist to help them control their disease.

Measure	National average (GSC patients)	GSC target	Notes
Diabetics using statins	71%	77.8%	The statin use performance score is better when it is higher. This means more diabetic patients are taking statins to reduce their risk of heart attack or stroke.
Asthma patients with not well-controlled disease and that are using high doses of rescue medication	28.8%	16.7%	Lower percentage indicates a better score. The goal is to decrease the number of patients who are using too much rescue medication and the number of patients who are not taking an asthma controlling medication.
Asthma patients not using a controller medication	24.6%	20%	
Patients completing the Health Coaching program	<1%	10%	A higher percentage of patients getting health coaching is better.

Safety

Some medications have a more significant risk of causing a severe health problem when used by older patients. For example, a reaction to a medication could cause a fall that could result in a hip fracture. The safety measure indicates the percentage of patients age 65 and older who received a high-risk medication.

Measure	National average (GSC patients)	GSC target	Notes
High-risk medication use	13%	7.7%	This measure is better when the percentage is lower. The goal is to reduce the number of patients taking high-risk medications.

So how are pharmacies doing?

The average scores for the first eight months of the program reveal an interesting snapshot of Canadian pharmacies' current approach to patient services and areas where they could improve.

The scores for the adherence measures are good; this is an indication that pharmacists are now taking on more of a role in helping patients be adherent to their medications. It is also a reflection of some of the efforts GSC has undertaken to improve plan member adherence through initiatives such as targeted disease communications, Stick2It – our digital medication reminder program, and, to be frank, our policy to dictate mandatory dispensing of a three-month supply of chronic medications.

The weakest scores are found in the disease management and patient safety categories illustrating that many people aren't getting the level of medication-related support they need from their health care professionals. For instance, the health coaching score is low, although pharmacists often tell us they want to increase their scope of practice (and revenue streams) through offering these types of programs.

However, this isn't simply a pharmacist problem – the issue is in our entire health care system. The current situation seems to be one where the physician writes the prescription and the pharmacist fills it, and if there's a problem, often no one notices. But disease management, really patient management, falls on both the physician and the pharmacist jointly. So there's a clear opportunity for pharmacists, working collaboratively with physicians, to step up and take on more of that patient management role.

To gain more insight on this, we talked to Ned Pojskic, GSC's leader, pharmacy and health provider relations. He used the asthma measures as an example of how pharmacy processes can lead to lower scores:

"Asthmatic patients are typically diagnosed by a physician and prescribed drug therapy to control their condition. The therapy often includes a 'controller' drug, which is to be used on an ongoing basis to keep asthma symptoms under control, and 'reliever' therapy which is to be used only in an acute asthma attack. The pharmacist will usually describe the function of both of these medications to a new asthmatic patient. But if that same patient starts to overuse their reliever medication, because of allergens or weather conditions for example, the pharmacist may continue to fill the prescription without engaging the patient and the physician to reassess disease control and recommend an adjustment to the controller therapy. The physician, on the other hand, is often not aware of the patient's poor control because the pharmacist continues to supply the patient with the reliever medication.

"Pharmacists have a unique vantage point and window into the problem and therefore have a responsibility to intervene and address the issue. At the moment, the pharmacy workflow and care delivery model doesn't consistently incorporate this type of patient management and ongoing following of patients, particularly for people with chronic disease. Ultimately, a change in culture is needed – a different way of thinking about who has ownership for the patient."

How can pharmacies improve their scores?

Through the scorecards, GSC is showing pharmacies where there are opportunities for improvement in the quality of care they offer to patients. But as we see it, the key to performance improvement, and improved outcomes, is partnering with the physician in the ownership of each patient. As Ned explains, "We're really talking about the bigger clinical picture, which means continuous evaluation of the patient's status, continuous monitoring of the patient's entire drug therapy regimen against their disease state, and continuous intervention in situations where necessary. While that may not be in all pharmacists' mindsets currently, it is in their standard of practice."

For more from Ned on GSC's Value-based Pharmacy initiative, don't miss episode 10 of our podcast, *And now for something completely indifferent*, featuring Ned and special guest William Chung, senior vice president, payor partnerships and pricing at Shoppers Drug Mart.

The average scores shown here reveal trends, and GSC's performance measures represent only a sample of all the different areas where a pharmacist could intervene. But in taking steps to improve their scores, pharmacies that take ownership of diabetic or asthmatic patients, for example, will ultimately take ownership for outcomes of other patients coming to the pharmacy. In other words, it starts the process for the creation of a culture of quality assessment and improvement. Ultimately, it leads to better care for plan members, better outcomes, and lower health care costs.

What's next?

Providing pharmacies with feedback on their performance is just phase one of GSC's Value-based Pharmacy initiative. In phase two, plan members will be able to view pharmacy performance through an online search tool. This will enable plan members to choose a pharmacy not only based on factors such as cost and location, but also actual quality of care delivered by that pharmacy. The search tool will be available in late 2018, so stay tuned for more information about this new initiative.

Eventually, in phase three, pharmacy reimbursement will be tied to performance scores to ensure that pharmacies providing higher quality of care are rewarded for their efforts, while pharmacies with suboptimal care may see their reimbursement diminished. This phase is currently in the development stage. We will be sure to keep you updated on phases two and three as they progress.



BEHIND THE COUNTER

What does Value-based Pharmacy mean for community pharmacies?



To provide some on-the-ground context to our topic of Value-based Pharmacy, we asked GSC pharmacist Leila Mandlsohn to explain what the measures mean for a practicing pharmacist in a typical community pharmacy.

Follow the Script: Welcome, Leila! The Value-based Pharmacy initiative is a fairly complicated subject, but what we're really interested in is: what should a pharmacist be doing to get good scores on the measures? Let's walk through a few of them starting with statin use in diabetics. We have long-established clinical guidelines, right? So what's the pharmacist's role in making sure the guidelines are being followed?

Leila: As a pharmacist in the community, the first thing to do is medication reviews with your patients where you can identify your diabetic population and their current treatment. Then a pharmacist can determine whether the treatment is aligned with what the clinical guidelines recommend. That means doing an individual patient assessment before you can say it makes sense for that guideline to be applied to that patient. Remember guidelines are just guidelines – you have to tailor them to the patient. A pharmacist needs to meet with the patient to understand their disease states and what treatments they're on to be able to say this patient should be on a statin, and that there are no obvious reasons for them not to be. But if they're not prescribed the statin, with no apparent reason why, that's where you need to intervene.

FtS: And what do you do to intervene? What does that mean?

Leila: You have to reach out to the physician who's treating the patient and make a recommendation to prescribe the statin.

FtS: How do you do that... by phone call or fax?

Leila: Yes, either one. In a community pharmacy, it's typically a fax. But that fax is not just going to say this patient needs to be on a statin. The pharmacist needs to provide a concise assessment about why they're making that recommendation.

FtS: So all this takes some time. Do pharmacists get paid to do that?

Leila: It varies by province. If we look at Ontario specifically, where I practise, the Ministry of Health and Long-

term Care has the MedsCheck review for diabetes. One full medication review is covered for reimbursement annually, and follow ups are also covered. In an ideal world, the pharmacist has that meeting with the patient at least once a year to go through a very in-depth medication review, and then any issues identified that require follow up – such as a statin not being part of the therapy when it should be – can be followed up. And, yes, the pharmacist gets paid to do that.

FtS: Do all doctors follow the recommendation when they get the fax?

Leila: No, not always; but some of them will act on it. I think how the recommendation is crafted impacts how the doctor views it. When you think about the way community pharmacists and primary care physicians interact, there is no natural relationship. When a doctor gets a fax from a pharmacist, they're getting a fax from a stranger. So there's no immediate credibility – the pharmacist has to build that credibility.

FtS: Isn't the issue as simple as: "My patient is a diabetic, they're not on a statin; they're supposed to be on a statin"?

Leila: There may be a reason why they're not on a statin, so both the physician and the pharmacist need to be looking at the same profile and have the same understanding. Sometimes the physician has some information that the pharmacist doesn't have explaining why the patient should not be on a statin. There has to be communication so they both are on the same page.

FtS: So does our Value-based Pharmacy target for pharmacists account for circumstances where diabetics shouldn't be on a statin?

Leila: We can't say with certainty that nine out of ten people should be on a statin. The guidelines simply don't give you that sort of information. The guidelines recommend, based on the clinical studies and the evidence, that unless there's a reason for someone not to be on a statin then they should be. It's really an individual decision by the physician assessing the patient to decide whether the risk outweighs the benefit. So we looked at where we are today, then we set a goal. We just want pharmacy performance to inch forward over time.

FtS: So we're confident more diabetic patients should be taking a statin than we see in our data.

Leila: Yes, for sure.

FtS: OK, got it. Let's move on to managing asthma. What are we measuring?

Leila: There are two measures and one looks at a sub-population of the first measure. The asthma with sub-optimal control measure looks at people with asthma medications who are overusing their rescue inhalers. Let me explain. The way asthma is supposed to be treated, the idea is to prevent attacks – the attacks that land the patient in the emergency room. So to prevent attacks, the patient needs to have their asthma symptoms under control with what we call a "controller medication." They're also given a "rescue inhaler" to use in the event of an asthma attack. If they are having an asthma attack, they need immediate treatment – that's the rescue. If a patient is using too much of that rescue, it means they're not well controlled. The second measure looks at whether the people who are overusing the rescue medication even have the controller treatment in place.

FtS: What should pharmacists be doing so they don't get a poor score on the asthma measures?

Leila: Basically the same thing they should be doing with the diabetic population. Identifying people with a certain disease, sitting with them, understanding what their disease is, what the treatment in place is, whether the disease is controlled or not, and making recommendations. Our measure is pointing out to the pharmacists, to say: "Hey, you have people over-utilizing their rescue medications; they're not controlled – something needs to be done."

FtS: Got it. So we are also measuring the use of high-risk medications in older people. How does this happen? Don't pharmacists have something on their system that says: "This patient is over 65 now, they should not take this medication"?

Leila: Often what happens is that patients were started on a medication before they turned 65. They're stable on treatment, so they just continue. We know there's a higher risk in the older population because they have lower kidney function, lower liver function, and so forth, but it's a gradual deterioration process. The idea isn't that someone turns 65, and they automatically need to be off the drug because, at the end of the day, they are presumably on the drug to treat an active disease. The pharmacist needs to continually reassess. Does it still make sense to continue on the drug? Is there a better drug that will achieve the same outcome but decrease the risk of side-effects? If there is, let's consider switching. It's really risk management.

FtS: The last measure we want to talk about is adherence. What role can pharmacists play in making sure patients are adherent to their drug therapy?

Leila: There are really two types of non-adherence. Primary non-adherence is: "I'm just simply not even filling my prescription ever. My doctor told me I need to start metformin because I'm a diabetic, but I'm not going to take it." And this can be for many reasons – they can't afford it, they don't believe in it, it upsets their stomach. Pharmacists have a role in identifying primary non-adherence when they're sitting with patients to do the medication reviews we've been talking about. Secondary non-adherence is when the patient is dispensed the drug, but they're not actually physically taking it. Yes, a pharmacist can't force the patient to swallow that pill, but a pharmacist can influence that patient's inclination to swallow it.

I recently heard someone talking about the path of understanding and the path of action, and I think patients have to have a good understanding for them to go down the path of action. Pharmacists have an opportunity to influence that path of understanding; they can say to the patient, "OK, I understand it upsets your stomach, or I understand maybe it costs too much, but here's why it's important to take the medication. Let's look at how we can work together to help you actually take it." It's about working with the patient – how the pharmacist talks to the patient, how they relate to the patient, and how they communicate with the patient.

FTS: In all your answers Leila, the common theme is that you have to sit down and talk more to a patient and do the documentation, and things like that, but doesn't that get in the way of pure productivity measures that pharmacies probably have in place?

Leila: We keep talking about changing the scope of the practice of the pharmacy and expanding the scope, but there are two streams of work. There's the dispensing, product-related work and there's the clinical work that we do. When I worked in a hospital, I actually didn't dispense drugs at all. We had pharmacy technicians in a dispensary taking care of that. The pharmacists were doing the clinical work, which is what we've been talking about here. If you're in your community pharmacy today trying to fit this in to your dispensing workflow, that's going to be a challenge. But I think there has to be a shift in how we see pharmacy in the community and the parallel workflows that need to take place.

DRUG REVIEW AT GSC...

To give you an idea of what drugs might impact your benefits plan next, every quarter *Follow the Script* highlights some of the drugs recently reviewed by GSC's Pharmacy and Therapeutic (P&T) Committee.

GSC CLASSIFICATION ¹	NEW DRUG ²	GENERAL INFORMATION	COST ³	COVERAGE DETAILS ⁴
INFLAMMATORY CONDITION				
<p>Biologic; High-cost; Specialty (Tier 5)</p>	<p>Dupixent™ (dupilumab)</p>	<p>Atopic dermatitis (AD) is a chronic, relapsing, inflammatory skin disease that can occur at any age but typically presents in childhood. The estimated prevalence in children is approximately 10 to 15 per cent, but most will outgrow the condition before adolescence with approximately 40 per cent continuing with AD into adulthood.⁵ AD is often characterized by a red, itchy rash usually on the cheeks, arms, and legs, but it can appear anywhere on the body. Other symptoms include skin dryness, oozing, crusting, and lichenification (leather-like thickening of the skin); however, itching is the hallmark symptom and is responsible for much of the disease burden (e.g., sleep disturbances, impaired functioning, and social and psychological impact). Although the exact cause of AD is unknown, genetics are thought to play a significant role, and AD is commonly associated with a family history of related disorders including eczema, asthma, and allergic rhinitis (hay fever).⁵</p> <p>Currently there is no cure, but standard of care involves treatments to decrease inflammation during flares along with precautions such as trigger avoidance to prevent new flares and avoid further complications (e.g., infections). Choice of treatment often depends on the patient's age, severity of the AD, and body area involved, but first-line treatment typically involves topical corticosteroids or topical calcineurin inhibitors. For those who fail to respond to topical treatment, oral corticosteroids or immunosuppressants and/or light therapy are often required.⁶</p> <p>Although there are treatment options available, none target the underlying inflammation, and efficacy is often limited with long-term use associated with side-effects. Although a majority of patients experience mild-to-moderate AD, an estimated 15 per cent experience severe disease with widespread areas of dry skin, incessant itching, redness, severe limitations of everyday activities, impaired psychosocial functioning, and nightly loss of sleep.⁷ Prior to the availability of Dupixent, those with severe disease who were not adequately controlled despite available options or who experienced side-effects from treatment were left with limited options.</p>	<p>\$\$\$\$</p> <p>Approximately \$30,000 per year</p>	<p>→ Specialty drug PPN</p> <p>→ Requires prior approval</p>

		Dupixent offers a novel targeted therapy that fulfills an unmet need. It is the first biologic to be available for AD and works by targeting the underlying inflammatory mechanisms by selectively targeting two molecules (IL-4 and IL-13) involved in AD. It has been approved by Health Canada for adults with moderate-to-severe AD whose disease is not adequately controlled with topical prescription therapies or when those therapies are not advisable. It is administered by injection at a loading dose of two injections (600mg) followed by a maintenance schedule of one injection (300mg) every other week. It can be used with or without topical corticosteroids.		
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AUTOIMMUNE DISEASE

Biologic; High-cost; Specialty (Tier 5)	Ocrevus™ (ocrelizumab)	<p>Multiple sclerosis (MS) is a chronic and progressive autoimmune disease of the brain and spinal cord in which the immune system attacks the myelin (the protective covering of the nerves) resulting in communication problems between the brain and the rest of the body. Canada has the highest rate of MS in the world with an estimated 100,000 Canadians living with MS.⁸ There are several types of MS; the most common is relapsing-remitting MS (RRMS), where the disease is characterized by clearly defined relapses (attacks or flare-ups) with complete, or nearly complete, recovery periods between attacks. In contrast, primary-progressive MS (PPMS) is characterized by a slow escalation in disability without defined relapses. Approximately 15 per cent of patients have the PPMS type.⁸ Unlike RRMS, which typically affects women three times more than men, PPMS affects both sexes equally and is typically diagnosed after age 40.⁸</p> <p>In Canada, while there are many approved treatment options for RRMS to reduce the number of relapses and slow the progression of disability, those with PPMS generally do not benefit from these therapies. Prior to the availability of Ocrevus, there were no Health Canada approved therapies for PPMS and many patients relied solely on supportive care (e.g., symptom management, rehabilitation, etc.).</p> <p>Ocrevus therefore fulfills an unmet need and is the first treatment option to be granted approval by Health Canada (with conditions) for the treatment of adults with early PPMS as defined by disease duration and level of disability, in conjunction with imaging features characteristic of inflammatory activity (to help support diagnosis). It is administered by infusion every six months following two initial loading doses (given two weeks apart).</p>	<p>\$\$\$\$</p> <p>Approximately \$33,000 per year</p>	<p>→ Specialty drug PPN</p> <p>→ Requires prior approval</p>
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GSC CLASSIFICATION ¹	NEW DRUG ²	GENERAL INFORMATION	COST ³	COVERAGE DETAILS ⁴
HEPATITIS C				
Traditional; High-cost; Specialty (Tier 5)	Vosevi™ (sofosbuvir/ velpatasvir/ voxilaprevir)	<p>Hepatitis C is a liver disease that is caused by the hepatitis C virus (HCV).⁹ Over the past few years, the emergence of novel, oral, direct-acting antivirals (DAAs) for the treatment of chronic hepatitis C has resulted in high cure rates (a greater than 90-95 per cent sustained virologic response [SVR] rates in most populations), shorter treatment durations, simplified regimens, and better tolerability. Despite high cure rates, a small portion (less than five per cent) will not respond to DAA treatment, and without treatment, patients will eventually progress to liver cirrhosis (scarring), liver failure, liver cancer, and/or transplantation.</p> <p>Prior to the availability of Vosevi, those who failed treatment with available DAAs were left with limited options. Vosevi therefore addresses an unmet need and offers an effective option (overall SVR rates of 96-98 per cent)¹⁰ for those who failed prior DAA treatment. Vosevi is a unique combination of three different DAAs, each targeting a different aspect of viral replication. It is the first sofosbuvir-based treatment regimen approved by Health Canada for the retreatment of DAA-experienced chronic hepatitis C patients, regardless of genotype, including those who fail treatment with an NS5A inhibitor (e.g., Epclusa®). Vosevi is orally administered once daily as a single-tablet regimen for 12 weeks.</p>	<p>\$\$\$\$\$</p> <p>Approximately \$60,000 per treatment course</p>	<p>→ Specialty drug PPN</p> <p>→ Requires prior approval</p>

Notes:

¹Traditional generally refers to small molecule compounds derived from chemical synthesis and also includes drugs not listed in Schedule D of the Food and Drugs Act; Biologic refers to drugs produced through biotechnology and listed in Schedule D of the Food and Drugs Act; High-cost refers to drugs subject to GSC's High Cost Drug Policies; Specialty (Tier 5) refers to drugs with an expected annual treatment cost of \$10,000 or more (certain drugs approaching the threshold may also be considered if clinically warranted).

²Brand (generic)

³Based on manufacturer list price, does not reflect pharmacy markup and dispensing fee. \$ <1,000; \$\$ 1,000–4,999; \$\$\$ 5,000–9,999; \$\$\$\$ 10,000–49,999; \$\$\$\$\$ ≥50,000.

⁴Applicable to all formularies unless otherwise noted. PPN refers to GSC's preferred pharmacy network program.

⁵Atopic Dermatitis, National Eczema Association, <https://nationaleczema.org/>.

⁶Lynde, et al. Canadian Practical Guide for the Treatment and Management of Atopic Dermatitis. Journal of cutaneous medicine and surgery. (2005). 8 Suppl 5. 1-9.

⁷Treatment of Atopic Dermatitis, UptoDate, <https://www.uptodate.com/>.

⁸About MS, Multiple Sclerosis Society of Canada, <https://mssociety.ca/>.

⁹Hepatitis C, Canadian Liver Foundation, <https://www.liver.ca/patients-caregivers/liver-diseases/hepatitis-c/>.

¹⁰Vosevi™ (sofosbuvir/velpatasvir/voxilaprevir), Product Monograph, https://pdf.hres.ca/dpd_pm/00040726.PDF.