Evaluation of FNHA's Health Benefits – Pharmacy Program for BC First Nations

PREPARED FOR: **First Nations Health Authority and as part of the Tripartite Framework Agreement Evaluation**

PREPARED BY: **Goss Gilroy Inc.**
Management Consultants
Suite 210-314 West Cordova St.
Vancouver, BC
V6B 1E8
Tel: (778) 379-5590
Fax: (613) 235-9592
E-mail: tweicker@ggi.ca

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GOSS GILROY INC.
Management Consultants
Conseillers en gestion

Executive Summary /Management Response and Action Plan

Background

British Columbia (BC) First Nations, through adopting two Consensus Papers, created a First Nations health governance structure that was further described and embedded via an agreement with federal and provincial governments. The *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Tripartite Framework Agreement) was signed in 2011 between Canada, the Province of British Columbia, and the First Nations Health Society, endorsed by the First Nations Health Council (FNHC). In 2013, the First Nations Health Authority (FNHA) assumed responsibility for health programs and services for BC First Nations, formerly held by the Health Canada's First Nations and Inuit Health Branch (FNIHB) – Pacific Region and associated headquarter functions, as part of a broader mandate to work with the Province of British Columbia to improve health services accessed by BC First Nations.

One of the programs transitioned to the FNHA by signing of the Tripartite Framework Agreement was the Non-Insured Health Benefits (NIHB) Program. The NIHB Program provides eligible registered First Nations individuals (both on- and off-reserve) with supplemental health benefits, including pharmacy, medical supplies and equipment, dental care, vision care, short-term crisis intervention mental health counselling, and medical transportation to access medically required health services not available on-reserve or in the community of residence. The pharmacy benefit area is the largest component of the NIHB Program.

In 2013, when the FNHA took a responsibility for delivery of the NIHB Program in BC, it entered into a buy-back arrangement with Health Canada. As a result, Health Canada continued to provide pharmaceutical benefits to FNHA clients on a cost recovery basis. On October 1, 2017, the FNHA transferred the provision of drug benefits from the NIHB Program to PharmaCare Plan W (Wellness). Plan W is a new pharmaceutical benefits plan designed for BC First Nations and delivered by PharmaCare, BC's public drug insurance program. Plan W is a 100% paid plan, with no deductibles or income testing, and is the first payer for FNHA clients at the pharmacy counter.

Purpose

This evaluation focuses on the FNHA's Pharmacy Program for BC First Nations with a primary focus on the transfer of the drug benefits to PharmaCare Plan W in 2017. The evaluation addresses a range of topics related to effectiveness, efficiency, governance structure, risk management and controls, and implementation of Plan W. More specifically, the evaluation reviewed the planning for and implementation of Plan W, the results of the transition and the opportunities for improvement and lessons learned that should be considered in the planning for changes to other health benefits. The evaluation addresses BC First Nation leadership and community requests for an independent evaluation of the transition to Plan W.

Method of Study

The methodology used to undertake this evaluation include:

- An extensive review of documents, files, and administrative data related to the FNHA's Pharmacy Program and the transition process.
- Interviews with 76 key informants, including 26 FNHA staff members, 19 First Nations clients, 16 Health Directors, 7 pharmacists and physicians, 4 provincial and federal partners, and 4 representatives of the service provider associations.
- Four focus group sessions, involving approximately 55 representatives of the FNHA, FNHC and First Nations Health Directors Association (FNHDA).
- A survey of FNHA clients and service providers, with 172 respondents completing the survey (32 Health Directors, 32 pharmacists, 9 physicians, 86 clients and 13 nurses).
- Two case studies: Success of the FNHA engagement activities with key stakeholders; and, Client barriers in accessing pharmacy benefits.

Key Findings and Conclusions

Key findings and conclusions arising from the evaluation are as follows:

1. **The decision to transition the delivery of pharmacy benefits from the NIHB Program to PharmaCare was informed by extensive consultations with First Nations representatives and internal research conducted by the FNHA.**

   Based on widespread consultations with First Nation representatives in 2011, a provision was included in the Tripartite Framework Agreement that required the transition of the delivery of pharmacy benefits from the NIHB Program to the FNHA. In 2016, based on results of the consultations and extensive research, the FNHA made the decision to transition the delivery of pharmacy benefits to PharmaCare as it had many advantages compared to other alternatives. Following the decision, the FNHA participated in Regional Caucus meetings to discuss and inform participants about the PharmaCare and benefits and potential negative impacts of the transition.

2. **The transition process was affected by tight deadlines and the scale of the transition which included all eligible registered BC First Nations, including those living in community and those living in urban areas and away from home. Despite these issues, the FNHA was able to successfully transition the delivery of pharmacy benefits to PharmaCare.**

   While FNHA management include individuals with extensive experience working with large scale transformative projects in the health system, the FNHA itself was only newly created. The organization did not have previous experience undertaking a change management initiative that include such a broad client base. Nevertheless, the FNHA created an effective governance structure and set of processes, established strong partnerships with the provincial government, contributed to regulatory changes, built the necessary infrastructure, and administered the transition of files and systems from NIHB Program to PharmaCare.

   The FNHA conducted extensive planning to understand and mitigate potential challenges and negative consequences of the transition. Some key actions taken by the FNHA include creating transitional special authorities to grandfather coverage into the new plan, establishing and expanding a call centre to address

client and service provider inquiries, increasing staffing within the health benefits unit to improve services for clients, and establishing a cross-border program to ensure clients living in border regions can access benefits. The FNHA also responded quickly and effectively to various issues that arose during the transition.

3. **Plan W created a significant shift in how pharmacy benefits are provided to BC First Nations. The transition resulted in greater utilization of the pharmacy benefits.**

   The shift from the NIHB Program to Plan W involved changes related to formularies, pricing, position of the first payer, dispensing fees, special authority and appeal procedures, coverage rules, and access to emergency supplies. The change has resulted in a significant increase in pharmacy benefits delivered to BC First Nations across a range of key metrics. In particular, the rate of growth in the number of claimants, claims, and expenditures in the first-year post-transition all exceeded the annual percentage increase the four years prior to the transition.

4. **The transition has generated a range of positive and negative impacts on both clients and service providers.**

   The transition enabled First Nations clients to gain access to the same care as other BC residents (e.g. accessing additional services provided by PharmaCare and provincial agencies), streamlined some processes, improved access to benefits for clients who live away from home, enabled clients to access more benefits initiated by pharmacists, and enabled some clients to shift to more effective therapies.

   The transition also generated some short-term negative impacts on clients. In particular, the differences in the formulary between the NIHB Program and Plan W resulted in many clients, including those with diabetes, experiencing a change in therapies which created confusion, increased anxiety and, for some, may have resulted in poorer health outcomes. In a survey, Health Directors, pharmacists, physicians and nurses estimated that up to one-half of their clients may have been impacted in some way by the transition. Some clients reported having to go back to their health care providers to obtain special authorities to be able to continue with their previous therapies or paying out-of-pocket, at least temporarily, for their medication. Many clients and service providers view the transition to Plan W as resulting in a more limited access to pharmacy benefits.

   The transition also impacted service providers. Pharmacists and physicians reported increased work related to administering special authorities, educating clients on the coverage rules, and processing forms. While most pharmacists benefited from some increases in dispensing fees and quicker payments, a few located in remote areas no longer qualify for provincial Rural Incentive Program payments.

5. **The transition was criticised by First Nation leaders, Health Directors and community members with regards to the FNHA handling the transition process and its engagement efforts with First Nation representatives.**

   The primary criticism was focused on the transition and was driven by two main factors. First, some key informants suggested that community representatives and Health Directors were not adequately involved in the selection of PharmaCare, design of Plan W, and planning and implementation of the transition. However, the findings of the evaluation indicate that as the evaluation was implemented under very tight deadlines, and due to evolving nature of the transition, the FNHA had very limited opportunities to incorporate changes in the design of the new program at the time of the transition.

Therefore, the FNHA put an emphasis on completing the transition first with the expectation that they would then work with First Nations and PharmaCare to improve Plan W.

Second, not enough emphasis was placed on educating and preparing clients and service providers to deal with issues that arose as a result of the transition and to mitigate potential human impacts. While the FNHA undertook extensive communication activities to inform clients and service providers about the upcoming changes, the efforts were constrained by tight deadlines, limited in-person communication, and miscommunication between the FNHA and FNHDA. While the FNHA expected the FNHDA to take a much greater role in preparing communities for the transition, Health Directors did not feel they were adequately engaged or prepared to respond to questions received from the community.

The FNHA has undertaken much more extensive efforts to consult with First Nation stakeholders as part of the transition to other health benefits (Phase 2 of the Claims Processing System Transformation (CPST) project).

6. **The FNHA has been largely successful in addressing the negative impacts of the transition and currently is working on addressing issues associated with the transition that still affect clients.**

   At the time of this evaluation, most issues and challenges of the transition have successfully been addressed by the FNHA with the organization continuing to work on addressing any outstanding issues that are still affecting clients. Some of these issues include limited knowledge of prescribers of the Plan W formularies, client access to benefits outside of the province, training provisions for diabetes clients, and some technical issues barriers to eligibility (e.g. not all clients have been transitioned, denial for services due to expired status card, and being taken off Plan W list without the person's prior knowledge). Some clients continue paying for their benefits (or portion of the cost) out-of-pocket (or through a private insurance provider) because they choose not to transition their benefits subject to the Reference Drug Program. These challenges have further been affected by limited knowledge among clients and service providers with regards to generic drugs, and appeal procedures under Plan W.

7. **The transition has placed the FNHA in a much better position to affect improvement in pharmacy benefits going forward.**

   The transition helped the FNHA to gain a greater role in the decisions related to the delivery of pharmacy benefits to First Nation clients. The FNHA has developed a strong partnership with the provincial government that should enable it to influence Plan W formularies in the future. The major benefit of the transition is that it has allowed the FNHA, and by extension BC First Nations, to have greater influence on the FNHA's Pharmacy Program and pharmacy benefits going forward.

Recommendations

The recommendations arising from the evaluation are as follows:

1. **Building on the progress made to date, the FNHA should continue to prioritize improving Plan W.**

   - The FNHA should work closely with BC First Nations and PharmaCare to further align Plan W with the objectives established for the FNHA's Pharmacy Program, particularly the emphasis on wellness, prevention, and the empowerment of individuals to access health programs and services.

   - Monitor the impact of Plan W on clients and service providers. While the evaluation has reported on the impact of the transition at a broad level, there is a need for further research and monitoring of the impact of the transition on individual clients or groups of clients.

   - Address key issues that have been identified such as:
     - Ensuring existing coverage addresses the most important clients needs.
     - Facilitating easier access to benefits out of province.
     - Addressing technical barriers to eligibility.
     - Creating mechanisms to notify pharmacists when special authorities are approved.
     - Completing the transition of the remaining clientele into Plan W.
     - Ensuring temporary coverage extended by NIHB is transitioned into a BC-based program.

   - Ensure robust monitoring of the FNHA's Pharmacy Program including tracking of outstanding issues related to solidifying and improving the transition, and analytics, such as utilization, to ensure data is available to support targeting population health and wellness interventions that address patterns of prescribing and drug utilization.

2. **The FNHA needs to engage extensively with First Nations and service providers in planning and implementing improvements to Plan W.**

   Building on the experience gained in Phase 2 of the CPST project consultations, the FNHA should engage with First Nation clients, Health Directors and political leaders to understand their perspectives and discuss issues and opportunities to improve Plan W. An emphasis should also be placed on engaging pharmacists, physicians, and nurses.

3. **The FNHA should develop an on-going education, training, and awareness program targeted at clients and service providers.**

   The FNHA's Pharmacy Program would benefit from increasing client understanding of generic and brand name drugs, Plan W coverage, policies, special authorities, appeal procedures, and where clients can seek assistance when encountering problems with accessing benefits. Continued efforts are needed to work with service providers, particularly those who predominantly serve First Nation clients (e.g. pharmacists, physicians, nurses) to continue to educate them on Plan W. Ongoing training for service providers should help to address existing knowledge gaps and train new people entering the system.

4. The FNHA should incorporate the key lessons into its operating policies and plans for similar initiatives in the future.

The FNHA has already incorporated a number of lessons learned into its activities related to transitioning of other health benefits. The transition to Plan W has illustrated the importance of:

- Building strong partnerships with stakeholders, engaging partners early in the process, and ensuring consistent and open communication.
- Undertaking meaningful engagement with First Nations representatives and taking a strategic and proactive approach to engaging clients and community stakeholders.
- Involving Health Directors, political leaders, and other champions in the communication and engagement activities.
- Establishing a strong governance system in charge of the transition including allowing sufficient time for project planning and monitoring, budgeting, making timely decisions, ensuring support from senior management, recruiting qualified staff members, and implementing proper change management procedures.

Management Response and Action Plan

Recommendation	Management Response and Action Plan
1. Building on the progress made to date, the FNHA should continue to prioritize improving Plan W.	FNHA responding to needs identified by clients: - Determining where special authority requirements can be removed (now removed on select diabetes medications). - Diabetes medications added to plan. - Co-pay issues addressed (e.g. insulin). - Coverage of Shingrix as a reimbursable benefit and working on future direct-bill options. FNHA building strong partnership with Ministry of Health to facilitate making improvements to Plan W: - Joint Strategic Plan guiding work. - Governance structure in place to facilitate making changes to Plan W within PharmaCare platform.
2. The FNHA needs to engage extensively with First Nations and service providers in planning and implementing improvements to Plan W.	FNHA Health Benefits Community Relations Team in place as a permanent team and will continue dialogue with community through focus group and dialogue sessions to guide improvements to the pharmacy benefit. FNHA Health Benefits Provider Relations Team to continue ongoing outreach and partnership support for our providers.
3. The FNHA should develop an on-going education, training, and awareness program targeted at clients and service providers.	FNHA's Health Benefits team is building and implementing a plan to support education of providers and improving information for our clients. This includes direct outreach and development of information materials: - A series of healthcare provider training and information sessions for pharmacist, nurses, and physicians have been and will continue to be held. - Fact Sheets developed (Diabetes Drug Coverage, Products used to Quit Commercial Tobacco products, Naloxone). Coyote Food Medicines: Storytelling to encourage client-healthcare provider interactions about drug therapies. The Coyote story has been shared with nurses, pharmacists, and physicians in primary care settings across BC.
4. The FNHA should incorporate the key lessons into its operating policies and plans for similar initiatives in the future.	Key changes responding to lessons learned to be applied in future work include: - Aligning the planning process of community and provider engagement teams. - Developing more robust communications. - Improving operational support and client service. - Working with health leadership throughout the process to validate our approach, include the FNHDA Technical Advice Process survey.

1. Introduction

1.1 First Nations Health Authority

British Columbia (BC) First Nations, through adopting two Consensus Papers, created a First Nations health governance structure that was further described and embedded via an agreement with federal and provincial governments. The *British Columbia Tripartite Framework Agreement on First Nation Health Governance* (Tripartite Framework Agreement) was signed in 2011 between Canada, the Province of British Columbia, and the First Nations Health Society, endorsed by the First Nations Health Council (FNHC).

In 2013, the First Nations Health Authority (FNHA) assumed responsibility for programs and services formerly held by Health Canada's First Nations and Inuit Health Branch (FNIHB) – Pacific Region and associated headquarter functions, as part of a broader mandate to work with the Province of British Columbia to improve health services accessed by BC First Nations. The FNHA is the first province-wide First Nations health authority of its kind in Canada. The FNHA seeks to improve the health and well-being of BC First Nations through effective health system partnership and integration, as well as management and funding of First Nations health programs. For the FNHA, success is marked not only by how well it has succeeded in fulfilling its commitments under the Tripartite Framework Agreement and the Canada Funding Agreement, but also by how well it has advanced First Nations values, perspective, and principles in the broader health system through which meaningful partnerships and change in health outcomes can be accomplished.

The FNHA enables programs and services in several different and complementary ways. A significant number of programs and services are funded by the FNHA and delivered by communities and their mandated health organizations. Depending on the nature of the funding agreement, communities can benefit from significant flexibility in the design and delivery of the programs, including areas such as Mental Wellness, and Healthy Child Development.

The FNHA also directly delivers a number of programs and services, many of which directly relate to and support the programs and services delivered by communities. These include areas such as Health Benefits, Nursing, and Environmental Public Health Services.

1.2 Purpose of the Evaluation

This evaluation focuses on the FNHA's Health Benefits – Pharmacy Program for BC First Nations. It addresses a range of topics related to effectiveness, efficiency, governance structure, risk management and controls, and implementation of Plan W.

Under the Tripartite Framework Agreement, the FNHA assumed responsibility for the pharmacy benefits in 2013. To deliver the program, the FNHA purchased services from FNIHB to process client claims for dental, drugs, and medical supplies and equipment. On October 1, 2017, the FNHA transferred the provision of drug benefits from the FNIHB Non-Insured Health Benefit (NIHB) Program to PharmaCare Plan W (Wellness), a new pharmaceutical benefits plan designed for BC First Nations.

The evaluation focused primarily on the transition to Plan W and subsequent implementation of the FNHA's Pharmacy Program. More specifically, the evaluation reviewed the planning for and implementation of Plan W, the results of the transition, and the opportunities for improvement and lessons learned that should be considered in the planning for changes to other health benefits.

1.3 Overview of the Report

The next chapter provides an overview of the FNHA's Health Benefits – Pharmacy Program for BC First Nations and describes the transition of the pharmacy benefits from FNIHB's NIHB Program to PharmaCare Plan W in 2017. Chapter 3 describes the evaluation design and methodologies including the evaluation scope and objectives, the evaluation issues and questions, and data reliability and evaluation limitations; Chapter 4 provides the evaluation findings related to planning and implementation of the transition; Chapter 5 provides evaluation findings related to change in formularies, processes, and procedures and identifies impacts of these changes; Chapter 6 highlights some of the key lessons that have been learned from the transition; and Chapter 7 contains the main conclusions and recommendations.

2. Transition to the FNHA and Plan W

This section provides an overview of FNIHB health benefits program, the transfer of that program to the FNHA in 2013, and the transition of the pharmacy component of health benefits to Plan W in 2017.

2.1 The Non-Insured Health Benefits (NIHB) Program

The NIHB Program is a long-established national health benefits program administered through FNIHB and provides eligible registered First Nations people (both on and off-reserve) and recognized Inuit residents of Canada with supplemental health benefits in a manner that contributes to their improved health status.

The NIHB Program provides access to a range of medically necessary, health-related goods and services when these benefits are not otherwise provided to eligible clients through private or provincial/territorial programs. Pharmacy is the largest component of the NIHB Program. Other elements include medical supplies and equipment, dental care, vision care, short-term crisis intervention mental health counselling, and medical transportation to access medically required health services not available on-reserve or in the community of residence.

The NIHB Program does not provide direct services to clients but instead relies on service providers (e.g. pharmacists) to deliver services to clients. Most of the program expenditures are provided through service agreements with enrolled providers who bill the NIHB Program directly for the payment of claims. NIHB Program clients are not required to contribute financially to their benefits (as there are no co-payments or deductibles).

The Program is a 'payer of last resort' (i.e. when clients are eligible for coverage under other plans, claims must be submitted to these plans first) for eligible First Nations and Inuit clients who are not covered through social programs, private insurance plans, or provincial or territorial health insurance.

2.2 Transition of the Pharmacy Program to the FNHA

Transfer to the FNHA in 2013

Schedule 5 of the Tripartite Framework Agreement mandated that the Pharmacy Program delivered in BC by NIHB be transitioned to the FNHA. Extensive discussions occurred regarding the transition of the pharmacy benefits and the development of the Health Benefits Sub-Agreements and Health Benefits Service Agreement. Consequently, in 2013, the FNHA began receiving transfer payments from FNIHB and assumed responsibility for the provision of drug benefits to BC First Nations. For Inuit clients residing in BC, the NIHB Program continues to deliver supplemental health benefits. To deliver the program, the FNHA purchased services from FNIHB to process client claims for dental, drugs, and medical supplies and equipment.

Program Delivery

The delivery of health benefits in BC is supported by four teams within the FNHA's Health Benefits team who work together to enhance health benefits and service access for clients.

- The **Operations** team delivers heath benefits to the FNHA clients through relationships with individuals, communities, and service providers. Operations works closely with other health benefits teams and community partners to support healthy, culturally safe medication access and use.

- The **Benefits Management** team provides support to health benefits operations by maintaining and implementing benefit policies and developing processes. The team collaborates, internally and externally, to support and align benefits and programs with organizational directions and community-driven transformations.

- The **Provider and Financial Management** team provides insight into health benefits usage through their analysis so the FNHA can be responsive to client and community needs. The team works closely with FNHA partners to monitor third-party adjudication of claims. It is also responsible for provider relations and audit.

- The **Data Analytics and Reporting** team ensures that quality health benefits utilization data is available and usable through powerful analytics and data management tools, which support better decision making.

Guided by the direction provided by communities and working in alignment with the FNHA's vision and plans, Health Benefits delivers benefits and services through its partnerships within the FNHA, with federal and provincial governments, service providers, and most importantly, with the communities that are served. FNHA Health Benefits support access to essential medical care for BC First Nations by covering Medical Services Plan premiums payments for FNHA clients. Working in partnership with BC's Ministry of Health (MOH) and Department of Indigenous Services Canada, the FNHA also provides pharmacy, medical supplies and equipment, dental, medical transportation, vision care, and mental health coverage. FNHA Health Benefits differs from private insurance plans in a number of ways. It uses a needs-based approach, with no client premiums, co-payments, deductibles, or annual maximums. This work has an increasing focus on wellness.

Objectives

The FNHA Pharmacy Program strives to provide benefits to BC First Nations peoples in a manner that:

- Is appropriate to the unique health needs of BC First Nations;
- Leads to improved overall health so that BC First Nations health status is comparable to other Canadians;
- Is financially sustainable;
- Facilitates empowerment of individuals to access health programs and services as and when they need it; and
- Focuses health services towards wellness and prevention.

Program Stakeholders

Key First Nation stakeholders of the program include:

- First Nation individual and families who have enrolled in the program to receive pharmacy benefits;
- First Nation community leadership;
- Organizations represented in First Nation Health Governance Structure;
- First Nation health service delivery organizations; and
- First Nation political organizations in BC.

2.3 Transition of Pharmacy Benefits to Plan W

On October 1, 2017, the FNHA transferred the provision of drug benefits from FNIHB to PharmaCare Plan W (Wellness), a new pharmaceutical benefit plan designed for BC First Nations. Plan W is delivered through PharmaCare, BC's public drug insurance program. Eligible FNHA clients transitioned automatically to Plan W.

Plan W is a 100% paid plan, with no deductibles or income testing. It is the first payer for FNHA clients at the pharmacy counter. All status First Nation individuals in BC and their children under one year old are eligible to receive benefits through the plan, with the exception of those identified by the BC MOH as not being eligible because they receive comprehensive drug coverage through either a treaty and land claims agreement or through a contribution agreement between government and a First Nations organization. First Nations individuals residing out of province who are visiting BC continue to be covered by NIHB rather than PharmaCare.

Expected benefits of the transition to Plan W for FNHA clients include:[1]

- Increased ease of access to benefits and services;
- A streamlined approvals process that reduces the number of steps needed for prescription approvals. Special authorizations (exceptions) would be completed more efficiently;
- Integrating benefits with the Province of BC will reduce confusion for clients who have often had to navigate both federal and provincial services;
- Increased access for FNHA clients to other PharmaCare plans and additional provincial programs;
- Over time, stronger relationships will develop with providers to better coordinate benefits and fully integrate pharmacy benefits within a client's circle of care. In addition to pharmacists and physicians/nurse practitioners, this includes stronger relationships with BC's specialty health agencies which have taken over responsibility for the provision of drug therapies for clients accessing treatment for cancer, kidney disease, organ transplants and HIV/AIDS; and
- The FNHA will be in a better position, working with the provincial government, to influence pharmacy benefits, better reflect the cultures and perspectives of BC First Nations and incorporate First Nations' models of wellness.

[1] Manager Messenger: Transition to Pharmacare, November 15, 2016

Other health benefits are currently being delivered through a buyback agreement with FNIHB. On April 16, 2019, the FNHA announced that starting in September, Pacific Blue Cross will administer benefits on behalf of the FNHA for dental, vision, medical supplies and equipment, and drugs not covered by PharmaCare.

3. Evaluation Methodology

This chapter describes the methodology employed to conduct an evaluation of the FNHA's Health Benefits – Pharmacy Program for BC First Nations.

3.1 Purpose and Scope of the Evaluation

While the scope of the evaluation includes activities and programming delivered through the FNHA's Pharmacy Program from 2013 to present, the primary focus is the transfer of drug benefits to Plan W in 2017. More specifically, the evaluation is expected to:

- Address the FNHA's learning needs regarding the program and support ongoing improvements to the program;
- Identify and synthesize lessons learned to inform recommendations to support the effective implementation of Phase 2 of the Claims Processing System Transformation (CPST) project;
- Enable the FNHA to respond to questions and concerns regarding the transition that have been articulated by FNHA clients and stakeholders; and
- Address BC First Nation leadership and community requests for an independent evaluation of the transition to PharmaCare.

The evaluation addresses a range of topics related to effectiveness, efficiency, governance structure, risk management and controls, and implementation of Plan W. It focuses on three key issues, including:

- Planning and implementation of Plan W;
- Results of the transition; and
- Lessons learned and opportunities for improvement.

This evaluation is aligned with, and the results will be used to inform, other ongoing evaluations undertaken by the FNHA including the Tripartite Framework Agreement Evaluation and the FNHA Evaluation.

3.2 Data Collection

This project was undertaken in two phases. The first phase consisted of initial interviews as well as a file and document review leading to the development of a detailed Evaluation Work Plan which outlined the strategies and methodologies which were implemented in the second phase of the project. Data collection undertaken in the second phase of the evaluation include:

- *Interviews with 76 key informants*. The FNHA provided a list of 35 key informants to be interviewed as part of the evaluation. The list include members of the FNHA Executive Team, FNHA Health Benefits staff, members of the FNHA regional teams, provincial and federal partners and representatives of service provider associations. In addition, 79 external stakeholders were identified during the interviews with key informants. These external stakeholders include pharmacists, physicians, First Nations community representatives, community leaders, and Health Directors. As demonstrated in the following table, 114 interviews were requested with 76 interviews completed. This includes 26 with FNHA staff members, 19 with First Nations representatives, 16 with Health Directors, 7 with pharmacists and physicians, 4 with provincial and federal partners, and 4 with representatives of service provider associations.

Table 1: Number of Key Informants By Category

Category	Total	Completed	Response Rate
FNHA Executive	5	3	60%
FNHA Health Benefits	15	15	100%
FNHA Regional	13	8	62%
Provincial	2	2	100%
Federal	2	2	100%
Service Provider Associations	6	4	67%
Pharmacists	18	6	33%
Physicians	2	1	50%
First Nations Representatives	35	19	54%
Health Directors	16	16	100%
Total	**114**	**76**	**67%**

Key informant interviews were conducted in-person and/or by telephone depending on the preference and location of the respondent. To undertake the interviews, an email was sent to each potential interviewee requesting their participation in an interview along with an interview guide. Follow up phone calls were conducted to schedule the most appropriate time for an interview. At least six phone follow-up or email reminders were sent to each potential respondent to schedule interviews. Some in-person interviews, particularly those with First Nation clients, were organized with help from community health staff members who assisted us with identifying potential respondents, and scheduling time and location for interviews. A site visit was conducted in the Interior Region in which in-person interviews with clients, pharmacists, community health staff members and Health Directors were conducted.

- *Four focus group sessions were conducted, involving approximately 55 representatives* of the FNHA, FNHC and First Nations Health Directors Association (FNHDA).

Table 2: Focus Group Sessions

Focus Groups	Sessions	Participants
Focus group with FNHDA Committee Members	1	5
Focus groups as part of FNHA-FNHC-FNHDA Joint Planning Session	3	~ 50
Total	**4**	**~55**

- *An extensive review of documents and files associated with the Pharmacy Program and the transition process.* A review was conducted which include historical background documents related to the FNHA, health benefits, the NIHB Program, requirements regarding the transition of pharmacy benefits to FNHA and documents associated with the transition process. The types of documents reviewed include contracts and agreements signed with project partners (e.g. Memorandum of Understanding (MOU), Letter of Mutual Accountability, Financial Framework Agreement, funding agreements); planning documents (e.g. project charters, master plans, governance structures, communication strategy); progress and status reports, financial and budget data, awareness raising materials and documentation on communication and engagement activities (e.g. information materials, brochures, newsletters, statistics on number of documents distributed); publications and presentations, results of the client satisfaction surveys, data on call center inquiries and documents produced with delivery partners (e.g. those produced by the FNHDA, MOH and FNIHB) related to the transition.

- *An extensive review of administrative data associated with the Pharmacy Program and the transition processes*. Several types of data were extracted and analyzed, including (i) data on program enrollment including the number of claimants, the number of claims, total expenditures and the number of days supplied per patient for five years prior to transition and the year after transition (October 1st, 2012 to September 30, 2018); (ii) data on drug formularies of PharmaCare and NIHB Program to understand differences between the two programs; (iii) data on claims submitted by clients for the periods of 12 months prior to and after the transition to analyse and review the changes that had happened in claims patterns between the two periods; (iv) data on claims supported through PharmaCare and NIHB during the first year after transition; (v) data on claims associated with prior approvals and special authorities during the year prior to and subsequent to the transition; (vi) data on claims associated with the residual list established to broaden coverage of certain products after the transition; and (vii) data on specific benefits and/or issues of importance to stakeholders mentioned during interviews, surveys, and focus groups. The objective of this analysis was to illustrate special cases as well as mitigation strategies that were implemented during the transition period. Examples of such specific analysis include analysis of over-the-counter (OTC) claims pre- and post-transition, review of the claims associated with diabetes drugs and test strips, and analysis of paid claims for ostomy supplies pre- and post-transition.

- *Surveys of 172 stakeholders including 86 FNHA clients, 32 Health Directors, 32 pharmacists, 9 physicians and 13 nurses.* The survey questionnaire was tailored to each group of respondents, pre-tested and finalized based on the results of testing as well as comments from representatives of the FNHA and other external stakeholders. The surveys were administered online over a period of about six weeks from February 2019 to March 2019.

  The source of the sample varied somewhat by stakeholder group:

  - For the survey of clients, a random sample of 400 potential respondents was selected from a list of clients who had previously agreed to participate in FNHA research or surveys. Two reminders were sent, yielding 86 respondents (a response rate of 22%). Of the 86 respondents, 66% indicated that they were eligible for Plan W, 8% indicated that they were not eligible for Plan W, and 26% were not sure. Those who were not eligible asked to terminate the survey, and their responses were not included in subsequent analysis. Most of the eligible clients (77%) who completed the survey lived in their home community while about one-quarter lived away from home. In terms of

age, 55% were 45 to 64 years of age, 31% were 25 to 44 years of age, 8% were over 65 years, and 6% were 18 to 24 years of age.

- The surveys of other stakeholders (i.e. Health Directors, pharmacists, physicians, and nurses) were administered with support from their respective organizations. A letter of invitation along with a link to the survey was emailed to Health Directors by the FNHDA, the survey for pharmacists was emailed to members by the BC Pharmacy Association, the survey to physicians was emailed by Doctors of BC and the survey to FNHA Community Health Nurses (both nursing stations and health center staff) was emailed by FNHA. The consultants worked closely with each respective organization to administer the survey (e.g. designing invitation email, preparing a dedicate website) and increase response rate. In particular, each group of respondents received at least two to three reminders to encourage their participation in the survey (except physicians who were emailed only once).

As demonstrated in the following table, respondents were drawn from each region.

Table 3: Distribution of Survey Respondents Across Regions

Region	Health Directors		Pharmacists		Physicians		Clients		Nurses		Total	
	#	%	#	%	#	%	#	%	#	%	#	%
Interior	7	22%	5	16%	1	12%	16	25%	3	23%	32	22%
North	8	25%	6	19%	3	33%	11	17%	8	62%	36	24%
Vancouver Coastal	4	13%	6	19%	3	33%	12	19%	2	15%	27	18%
Vancouver Island	10	31%	11	34%	1	11%	16	25%	-	-	38	26%
Fraser Salish	3	9%	2	6%	1	11%	5	9%	-	-	11	7%
Other	-	-	2	6%	-	-	3	5%	-	-	5	3%
Not Noted	-	-	-	-	-	-	23	-	-	-	23	-
Total	**32**	**100%**	**32**	**100%**	**9**	**100%**	**86**	**100%**	**13**	**100%**	**172**	**100%**

- *Two Case Studies* were conducted to undertake further in-depth analysis on particular issues. The first case study explored the effectiveness of activities undertaken by the FNHA to engage with representatives of communities, health benefit clients and other First Nation stakeholders on decision related to the transition. The second case study focused on factors that may have impacted access to therapies, including differences between the Plan W and NIHB Program formularies, the use of special authorisation procedures and appeal processes. Each case study involved a set of interviews and a review of documents, data, survey results and key informant interviews.

3.3 Data Reliability and Limitations

The main strategy to achieve high reliability of the findings has been the inclusion of multiple lines of evidence in the methodology. Interviews and surveys were conducted with a broad cross-section of stakeholders involved in, or affected by, the FNHA's Pharmacy Program. In addition, an extensive document and administrative data review was conducted. Most representatives of FNHA who were involved in the transition process, or the design and delivery of the FNHA Pharmacy Program activities and programming, were interviewed. The key findings and conclusion presented in this report have been triangulated and confirmed with two or more lines of evidence to ensure reliability. As part of this step, the consultants took into account the strengths and limitations of each line of inquiry.

Despite these steps, it is important to acknowledge certain limitations.

- The interview and survey results represent the opinions of key informants and survey respondents. Responses are impacted by memory, are influenced by respondent experiences (which can include stories related to them by others) and may be subject to respondent bias (e.g. many of the key informants were directly involved in the planning and implementation of the transition or affected by it). Several measures were implemented to reduce the effect of respondent biases: (i) the purpose of the evaluation, its design and methodology and strict confidentiality of responses were clearly communicated to respondents; (ii) the interviews were conducted by highly experienced interviewers; (iii) follow-up questions were often asked to clarify information and better understand the context and basis for the comments made; and (iv) findings of the interviews were cross-checked with results of surveys and case studies.

- The evaluation made extensive use of administrative data to compare differences in claims during the period prior to the transition and after the transition. While changes in claims are noted, it is not possible to assess the extent to which any changes are attributable to the transition (a variety of other factors, external to the Pharmacy Program, impact on claim patterns). Furthermore, the administrative data analysis provides general trends and patterns in enrolment and claims and does not allow for an assessment of the impact of those changes on clients (e.g. whether the changes resulted in improved health outcomes, no change in outcomes, or worsened outcomes).

- Input on the impact of changes on clients was obtained through surveys with clients. However, due to the small sample size, sample biased towards on-reserve residents and the self-selected nature of the sample, the survey is not necessarily representative of the broader client population. To mitigate this limitation, the findings of the survey were complemented with client interviews conducted in-person or by telephone.

- In addition, the consultants conducted focus groups, key informant interviews, and surveys with other stakeholders including Health Directors and nurses, members of the FNHDA and FNHC, pharmacists and physicians, and other First Nations representatives who tend to be close to the communities and have the first-hand experience with some of the clients who are impacted by the transition.

4. Planning and Implementation – Key Findings

This chapter provides key findings of the evaluation with regards to activities implemented to plan for transition and engage and inform with First Nation clients, Health Directors, and service providers about the changes in the Pharmacy Program.

4.1 The Decision to Transition to Plan W

The transition of health benefits to the FNHA was a requirement of the Tripartite Framework Agreement, which also included a financial incentive for the FNHA to complete the transition by the end of 2017.

The Tripartite Framework Agreement, signed in 2011, required the NIHB Program to be transitioned to the FNHA. According to the Agreement, Canada would provide funding to the FNHA to support the transfer of all federal health programs handled by FNIHB – Pacific Region, including the NIHB Program. Schedule 5 of the Agreement states that: *"FNHA will design, plan, manage and deliver a health benefits program that replaces the NIHB Program and that includes the actions and commitments required for a smooth transition and to maintain continuity of health benefits services to clients*." [2]

In 2013, when the FNHA took a responsibility for delivery of the NIHB Program in BC, it entered into a buy-back arrangement with FNIHB. As a result, FNIHB continued to provide pharmaceutical benefits to FNHA clients on a cost recovery basis until October 1, 2017 when the FNHA transferred the provision of drug benefits from the NIHB Program to Plan W.

The challenge for the FNHA was to first determine how the FNHA's Pharmacy Program would be delivered in the future and then to facilitate transition to that model within a relatively short period of time. The original expectation was that the transition would commence soon after the FNHA took responsibility and would cover the full range of health benefits. The Tripartite Framework Agreement indicated that the transfer would occur in phases or blocks as the FNHA and Canada agree and would be completed within two years of the signing of the Agreement or later time based on agreement."[3] Key informants note that as the two-year time frame was approaching, FNIHB put increasing pressure on the FNHA to start the transition process.

[2] *BC Tripartite Framework Agreement on First Nations Health Governance.*
[3] Ibid.

Based in part on the results of a Request for Expressions of Interest from potential suppliers and the FNHA's internal investigation, it was determined by the FNHA that PharmaCare was the supplier best positioned to deliver pharmacy benefits.

In 2014, the FNHA issued a Request for Expression of Interest to solicit services from a third-party insurance provider that could assist in delivering pharmacy benefits. Based on the results of this request, the decision was made to start discussions with PharmaCare without an official tender or request for proposals process. The decision to select PharmaCare was based on a number of advantages that it held over other potential suppliers (e.g. Blue Cross, Green Shield, Great-West Life) as well as the willingness of the new provincial government to support the transition. Some advantages of PharmaCare as a service supplier include its extensive infrastructure (e.g. PharmaNet, the province-wide network that links all BC pharmacies to a central data system), well established processes for managing the formulary (e.g. scientific and evidence-based procedures for selecting effective therapies), strong links with service providers (e.g. BC pharmacists and physicians work closely with PharmaCare), better integration within the provincial health care system and alignment with provincial standards (e.g. provincial priorities and service delivery systems are reflected in PharmaCare formularies). Furthermore, PharmaCare offered easier access to pharmacy benefits (e.g. First Nation clients can access the services by BC Service Card only) and access to additional services and programming provided by provincial agencies and PharmaCare.

At the time of transition, the FNHA also conducted its own review of the existing drug programs and decided that BC PharmaCare was regarded as one of the most advanced public sector drug programs in Canada. In particular, a review of different coverage programs has demonstrated that reference drug programs (RDPs) are safer and more effective than simplistic fiscal drug policies, including fixed co-payments, co-insurances, or deductibles in terms of providing a full drug coverage for as many patients as possible in the most efficient manner.[4] A review of the BC's RDP program implemented from 1995 to 1997 have demonstrated that implementation of the RDPs[5]:

- Did not increase in the rate of discontinuation of drug therapy;
- Temporarily increased implementation cost, as physicians monitored patients more closely after switching them from a high-priced to a reference drug;
- Considering multiple spending components, RDP produced sizable net savings mostly due to existing drug users switching drugs and increasingly to new users starting drugs priced below the reference price; and
- No severe negative effects on clients could be attributed to RDPs in BC.

A review of the relevant literature demonstrates that due to the reference pricing policy, overall costs for drugs in BC, subject to reference pricing, are the lowest in the country. Prescription drugs expenditures in BC as a percentage of total provincial government expenditures on health was declining over the past few decades (6.5% in 2000, 5.9% in 2008 and 4.9% in 2015).[6] While at the

[4] Schneeweiss S. (2007). Reference drug programs: effectiveness and policy implications. Health Policy, 81(1):17-28.
[5] Ibid.
[6] Fiona M., et all. (2016). Canadian Publicly Funded Prescription Drug Plans, Expenditures and an Overview of Patient Impacts.

same time the average household out-of-pocket expenditures in BC on prescribed medicines and pharmaceutical products was one of the lowest in Canada, below national average.[7]

4.2 Consulting With First Nations About the Changes

Extensive consultations were undertaken with First Nations representatives early in the process. These consultations contributed to the decision to transition pharmacy benefits to a program administered by the FNHA and identified opportunities to improve how pharmacy benefits are delivered.

Key informants note that consultations with community stakeholders led to the initial decision to incorporate a requirement to transition the delivery of health benefits from NIHB to a FNHA program into the Tripartite Framework Agreement. In addition, the design of the program and the decision to select PharmaCare was further informed by input obtained through discussions held with First Nations.

In 2013, when the FNHA first assumed responsibilities for health programs and services for BC First Nations from the FNIHB, the FNHA, FNHDA and FNHC created a Collaboration Committee consistent with the mandate established by BC First Nations for each entity. The Committee created a bilateral Health Benefits Working Group on Service Improvements. In January 2014, the FNHC and FNHDA agreed to form a Joint Transition and Transformation Committee which consisted of one FNHC and one FNHDA representative from each of the five regions (total of 10) and include representation from the FNHA. According to key informants, as part of these committees and working groups, the FNHA held numerous discussions with members of the FNHDA and FNHC on the issues and problems that communities faced with regards to drug benefits and identified strategies and approaches to address them.

Furthermore, in 2013, in partnership with the FNHC and FNHA, FNHDA developed and administered a short online survey with 116 Health Directors to gather their feedback and technical advice for improving the Health Benefits program. The results of the survey were summarized into 53 recommendations provided to the FNHA to consider during the transition process.

In addition, over the past five years, a number of discussions were held at Regional Caucus meetings where community representatives and Health Directors provided feedback on shortcomings of the existing NIHB system and identified issues to be addressed as part of the transition.

Once the decision to transition to PharmaCare was made, the FNHA started a process of engagement with First Nations with regards to the design of the new program. In particular, members of the FNHA transition team attended a number of Regional Caucus meetings and the FNHDA Board of Directors meetings where they informed participants (e.g. Health Directors, community representatives, community leaders) about the PharmaCare and the transition. The presentations included a discussion around benefits of the transition (e.g. better alignment of the new program with provincial practices and standards, prescribers' familiarity with PharmaCare, easier process for special authorizations, improved access to palliative care) and expected challenges (e.g. first attempt to reach out to FNHA clients, issues with out of province claims, requirement to transition

[7] House of Commons (2018). Pharmacare Now: Prescription Medicine Coverage For All Canadians: Report Of The Standing Committee On Health.

some clients to comparable drugs on the PharmaCare formulary). The presentations included key changes to the program (e.g. change in therapy, out of province travel, OTC medication), potential impact on clients (e.g. worse case scenarios) and discussions to find solutions to mitigate these impacts.

Many key informants (particularly those outside of the FNHA) felt that further involvement of First Nations stakeholders in the planning process would have better enabled the FNHA to anticipate and mitigate potential negative impacts.

Some key informants argued that not enough emphasis was placed on assessing potential human impacts of the transition (e.g. the impact on clients and service providers of changes to long-established processes, the extent to which differences in the formularies would require changes in therapies for clients, and how those changes could negatively impact on clients in terms of adding to confusion and stress as well as potentially contributing to poorer health outcomes). Various key informant groups, including Health Directors, representatives of the FNHC, other community representatives and regional representatives within the FNHA, felt that more should have been done by the FNHA to incorporate the perspective of clients in planning the transition.

The FNHDA and FNHC representatives indicated that they were not adequately consulted as part of the transition process; they were not able to discuss and provide input into the design of the specific elements of the new drug plan; and they felt largely left out of the decision-making process and had limited control over the changes that would affect their communities. These key informants felt that they had no influence over the design of the new program even though they were often viewed as having responsibility for it by community members who saw them as the point person for the system which brought in the change. Community stakeholders felt they should have had the opportunity to review and rate the advantages and disadvantages of various available plans before the decision was made to select PharmaCare and that they should have been able to provide input into the design of the new plan to ensure that it addressed their concerns.

According to these key informants, some of the negative consequences of the transition could have been avoided (or predicted earlier) if the FNHDA and FNHC had been actively participating in the planning of Plan W and providing their input at this early stage. Some key informants felt that Health Directors are better positioned than FNHA staff to understand how the transition would affect people on the ground and in communities. They could have provided valuable advice on the key risks and potential mitigation strategies, the structure of the new FNHA's Pharmacy Program, and strategies to roll out the new program to minimize negative impacts in the short and long term.

Members of the FNHDA felt that the FNHA did not make efforts to engage Health Directors until the decision was made to transition to PharmaCare. Some FNHDA Board members saw this as being inconsistent with the overall governance structure for First Nations health in BC, in which the role of the FNHDA is to provide technical advice to the FNHA for First Nations health services.

According to key informants within the FNHA, various factors contributed to not consulting more extensively with Health Directors and community leaders in the selection of PharmaCare and planning of Plan W.

- Extensive early consultation had already been undertaken with a broad cross-section of people, leading to the requirement to transition as part of the Tripartite Framework Agreement.

- PharmaCare was viewed as the most obvious choice as a supplier for the delivery of pharmacy benefits.

- The structure of Plan W continued to evolve throughout the spring, summer and fall of 2017, leading up to the launch date of October 1, 2017. The opportunity to get input on the design was therefore constrained by the evolving nature of Plan W, combined with time and resource constraints. The FNHA was under increasing pressure from FNIHB to complete the transition.

- There were limited opportunities to make significant changes to Plan W in the short-term. PharmaCare was hesitant to make any significant changes until the FNHA was fully familiar with the system. The implicit focus was on accomplishing the transition first, assessing the results, and then working to make improvements to the system.

- Some key informants perceived that most of the changes were not material and would not be obvious to many clients. While the transition would result in some changes in therapies, most clients would transfer relatively easily from the NIHB formulary to the Plan W formulary. Strategies such as the extensive use of special authorities would smooth that transition. The key challenge was viewed as the ability to inform clients and services providers of the upcoming changes, particularly those who may be impacted by the changes.

The major benefit of the transition is that it would allow the FNHA and by extension BC First Nations to have greater influence on the FNHA's Pharmacy Program and pharmacy benefits going forward. The transition was viewed mostly as an important step towards creating a platform through which future changes could be made. The FNHA saw the primary need for consultation to be after the transition (not before), when it would work with key stakeholders to determine how Plan W should evolve over time to better meet the health and wellness needs of First Nations.

4.3 Preparing for the Transition

The FNHA faced some significant challenges in preparing for the transition. As a newly established organization, the FNHA had to build necessary infrastructure, establish partnerships, undertake extensive planning, and reach out to and inform a large number of clients about the changes.

The transition required extensive planning, close coordination with both the federal and provincial governments, a significant legislative change, engagement activities targeted at a wide range of stakeholders, and extensive research and analysis to assess the potential client, service provider and financial impacts of the transition.

While the FNHA management include senior people with extensive experience in working in the health system, the organization itself was only newly created (and still very much in the process of hiring staff and creating an organizational structure and culture). As a new organization, the FNHA did not have experience in working with other insurance companies, PharmaCare or the provincial government in the delivery of health benefits and no track record of undertaking such major change initiative. As a result, various partners including the federal and provincial governments were reluctant to start working with the FNHA until it could determine a course of action and make progress towards implementation.

The FNHA also did not have previous experience with running a large scale information campaigns to reach out to its client base. It did not have up-to-date client contact information and lacked proper communication channels that could effectively inform clients about transition and prepare them for the changes. In particular, clients living in urban areas and away from home, were to most difficult to target as there were no effective mechanism to collect their contact information. Furthermore, the communication activities had to be designed and implemented within very short period under tight deadlines, which did not allow adequate time for planning, testing and improving the communication tools and resources.

After some initial difficulties, in 2015, the FNHA put in place a broad-based governance structure that proved effective in bringing together the range of capabilities, functions, and skills needed to plan and successfully complete the transition.

An initial attempt to establish an effective governance structure and put processes in place to manage planning and implementation of the transition was not successful. At that time, the initiative was led by the Information Management Information Technology team within the FNHA and took a more traditional information technology project management approach. As the project requirements became further defined, senior management determined that a different governance structure, approach to the transition, and set of skills would be required.

The result was that the transition activities were slowed down in 2014 while the FNHA created a new governance and project implementation structure. In 2015, the FNHA created and launched a more formal and broad-based governance structure which was more effective in bringing together the range of capabilities, functions and skills needed to plan and successfully complete the transition.

Table 4, illustrates the governance structure which includes an Executive Committee and five working groups. The Executive Committee was created to provide oversight to project implementation and high-level vision and guidance. The Committee was chaired by the FNHA Chief Executive Officer and included other senior staff members such as Chief Operating Officer and Vice President of Health Benefits as well as the chairs of the five working groups. The Committee was scheduled to meet twice a month and/or upon request when needed.

Working groups were established to undertake various aspects of the transition including communications and engagement, finance, organizational changes, information management and privacy and design of the new plan. Each working group had defined objectives, was chaired by a senior FNHA staff member and had a project manager, business lead and executive lead. Working groups met monthly and discussed and made decisions on critical issues associated with specific areas of the transition process.

The Portfolio Manager was hired as an external contractor to provide oversight over the execution of the project activities, deliverables, milestones, and schedules. The manager was a member of each working group and provided guidance to ensure alignment with overall project objectives and scope among the working groups.

Table 4: Transition Governance Structure

Groups	Membership	Objectives	Roles & Responsibilities
Executive Committee	9 Members including 4 Core members (Chief Executive Officer, Chief Operating Officer, Chief Administrative Officer , VP of Health Benefits), Portfolio Manager; and Chairs from the four working groups	• Provide high-level guidance and decision-making • Receive status reports from Executive Sponsor (or delegate) on a monthly basis. • Invite working group chairs to provide updates on deliverables	• Regular meetings (twice per month) • Additional on-request meetings regarding issues, risks and action items • Some issues discussed and addressed include OTCs, out-of-province access to benefits, risk register and mitigation strategy, go-live implementation plan, launch readiness, call centre improvements, escalation pathway, community engagement, and guiding principles
Working Group on Communications and Engagement	6 Members including Executive Director (Chair); 2 Directors (Communications and Benefits Management); Team Leader (Health Benefits and Strategic); Manager (Engagement and Planning); and Portfolio Manager	• Stakeholder Analysis • Communication & Engagement Strategy and Implementation • Enrollment	• Meeting on a monthly basis • Discussing and identifying issues and risks related to communication/developing mitigation strategies • Creating communications strategy and plan to deliver multiple communications and engagement activities for targeted audiences
Working Group on Finance	6 Members including: Chief Financial Officer (Chair), 3 Directors (Financial Planning, Analytics, Benefits Management), Health Economist, Portfolio Manager	• Cost estimates current vs. new model • Reconciliation processes	• Meeting on a monthly basis. • Developing work plans in cooperation with the Portfolio Manager • Discussing and identifying issues and risks in relevant areas and implementing mitigation strategies • Acting as both decision-making on issues of scope and advisory capacity in other areas. • Ensuring that the FNHA organizational culture, values, principles and directives are part of the project culture at all levels
Working Group on FNHA Organizational Changes	8 Members including VP, Human Resources (Chair), Chief Financial Officer (from Finance Working Group), 3 Directors (Operations, Benefits Management, Communications), 2 Managers (Transformation, and Human Resources); Portfolio Manager	• Organizational re-design • Staff engagement • Labour relations	
Working Group on Information Management and Privacy	6 Members including VP, Innovation and Information Mgmt. (Chair); 2 Directors (Risk Mgmt., and Analytics; Manager (Privacy); Lawyer (Legal Service); Portfolio Manager	• IM/IT infrastructure design and implementation • Privacy-related issues	
Working Group on Plan Design	5 Members including: VP, FNHB (Chair), Director (Benefits Management), Pharmacist Lead, FNHA; Team Lead (Health Benefits and Primary Care); Portfolio Manager	• Plan design and gap analysis • Eligibility • New HB processes (current vs. future)	

(Source: *Claims Processing System Transition Project – Communications and Engagement Terms of Reference Version 0.4, CPST Governance Organizational Chart*)

Key informants who were involved in the transition process identified various strengths of this governance structure. The creation of a formal and multi-layered decision-making structure with a clear division of roles and responsibilities was viewed as an industry best practice for undertaking complex change management assignments. The FNHA was successful in using this best practice by creating an Executive Committee and specific working groups and ensuring clear division of roles and responsibilities. Each working group was designed to focus on targeted aspects of the transition, facilitating coordinated efforts to complete the tasks effectively. The Executive Committee ensured that the transition processes were supported at the most senior level within the FNHA.

Key informants note that the external consultants and senior FNHA staff members who were involved had the necessary skills and expertise to undertake such a complex initiative. This contributed to building trust and collaborative partnerships with project partners (e.g. MOH), producing quality results under stressful and tight deadlines and facilitating successful implementation of the transition.

The transition was supported by the adoption of effective change management techniques including documentation, processes and procedures. Key informants note that detailed project management documentation was prepared, which defined the decision-making structure and personnel with decision authority, described procedures for identifying risks and issues of high and medium priority, and established a quick decision-making process (e.g. the escalation process). The approach ensured that the decision-making structure during the transition process was clear and enabled the team to address critical issues in a timely manner at the time of the transition.

The effectiveness of the governance and decision-making structure was supported by the involvement of key partners such as MOH and FNIHB. The FNHA signed an MOU with each partner, clarifying the roles and responsibilities related to the transition and establishing a Joint Steering Committee. The Committee involved senior representatives from each organization and held regular meetings to discuss key aspects of the transition and coordinate the activities.

Working groups were created within the Joint Steering Committee to implement different aspects of the transition. For example, the PharmaCare Working Group, which included a multidisciplinary team of directors from the FNHA and directors and senior managers from PharmaCare and the MOH, was in charge of coordinating the activities of Plan W. A Policy Working Group was created to coordinate changes at the policy level which were necessary to create and implement Plan W. The approach helped to develop very productive business relationships and trust between the MOH and the FNHA and helped to facilitate the transition process. The meetings organized within the working groups, in general, were collaborative, highly productive and provided effective guidance and oversight. The working groups were generally able to make critical decisions quickly and, when necessary, communicate the results to the Steering Committee for review and approval.

Along with partnerships through the Joint Steering Committee, the FNHA engaged directly with the MOH throughout the transition process. This partnership involved weekly meetings to coordinate activities, regular email exchanges and in-person meetings. One of the most significant impacts of this partnership was a regulatory change by the Province of BC in early March 2017, which enabled First Nations to participate in PharmaCare.

Key informants also note several areas of weakness within the governance structure, including occasional delays in decision-making process (e.g. the Executive Committee met less often than

anticipated due to the busy schedules of senior management and conflicting priorities), difficulties in coordinating activities between project partners (e.g. with FNIHB and MOH) and within working groups (efforts to coordinate activities between the different groups were not always successful, given the transition was being implemented under tight timelines).

The governance structure enabled the FNHA to work with its partners in successfully completing various tasks that were critical in enabling transition of the delivery of pharmacy benefits from NIHB to PharmaCare.

Some of the key elements of the transition include:

- *Developed the relationship with PharmaCare.* In January 2017, a high-level Framework Agreement was signed by the FNHA Chief Executive Officer and BC Deputy Minister of Health. The Agreement include guiding principles to facilitate First Nations client access to BC's PharmaCare program. Following the initial agreement, a detailed MOU was signed in February 2017 between the FNHA and MOH which set out the terms and conditions for the provision of pharmacy benefits to eligible First Nations through a new plan to be established within the PharmaCare program.[8] According to the MOU, the MOH and the FNHA agreed to work together to *"improve the health status of First Nations in British Columbia, and to build a more responsive and more integrated health system that will benefit all British Columbians."*

- *Created the funding mechanism for Plan W.* The FNHA-PharmaCare Financial Framework Agreement was signed to clarify the financial aspects of Plan W administration and management. The Agreement was signed on January 27, 2017 by the FNHA and the MOH outlining the details of the financial relationship between the two organizations.

- *Introduced legislative changes.* In March 2017, an amendment was made to the *Pharmaceutical Service Act*, Drug Plans Regulation to enable BC First Nations to participate in PharmaCare.

- *Developed a communication strategy to clarify roles and responsibilities and open lines of communication.* A formal Engagement and Communication Strategy was prepared to establish models of communication between the FNHA and the MOH. The strategy defined key points of contact in each organization, their respective roles and responsibilities and the best methods of communication.

- *Defined the processes for sharing of data and protecting client confidentiality*. An Information Sharing Agreement was signed between the FNHA and the MOH, which outlined processes and procedures that are used to share data while protecting client personal information.

- *Implemented steps to operationalize needed changes within the MOH, Health Insurance BC and the FNHA.* To undertake technical and operational aspects of the transition, the FNHA created a CPST Project. The objective of the CPST project was to transition pharmacy benefits from the 'buy-back' arrangement into new partnerships and a made-in-BC approach. In 2017, a Master Project Plan was created to support the transition process within the MOH. The Plan described the purpose and objectives of the assignment, its budget and stakeholders and identified the scope of the activities to be implemented. Similarly, Health Insurance BC Project Charter was

[8] PharmaCare MOU Briefing and MOU between FNHA and MOH

developed which defined the PharmaCare Benefit Plan Implementation project in terms of its objectives, scope, and key deliverables, and described how the project would be managed.

- *Created transitional special authorities to grandfather coverage into the new plan*. In preparation for October 1, 2017, over 110,000 transitional special authorities were implemented, enabling clients to continue to receive their existing therapies (i.e. grandparenting coverage). Over three-quarters of the special authorities (78%) were indefinite, while 22% were set to expire within a 12 months period (15% were to expire in four months, 6% in six months, and 1% in 12 months).

- *Established a cross-border program.* As the program is administrated by the Government of BC, PharmaCare's coverage and services do not extend outside the province. Some BC First Nations residents located in communities close to the Yukon or Alberta borders have commonly purchase their therapies from pharmacies in neighbouring jurisdictions. Provisions were therefore established to enable neighbouring pharmacies to provide the same benefits as PharmaCare.

- *Created a call centre to respond to inquiries from clients, service providers and other stakeholders.* Prior to the transition, the NIHB Program did not have a call centre where clients and service providers could receive information. During the process of planning the transition, the FNHA determined that it was important for their clients and service providers to have a 1-800 number that they could call should they need assistance or have questions about the transition. As a result, in the two months prior to the transition date, resources were dedicated to developing the infrastructure, obtaining software, and recruiting and training staff members to respond to customer inquiries through the toll-free number. On the date of the transition, the call centre was functional although some capabilities were still under development.

- *Built a data warehouse and populated it with large volumes of client data taken from the old system*. It took about one year to build the data warehouse. At the same time, large volumes of special authorities were being issued (e.g. covering prescriptions issued right up to the day before the transition) which needed to be entered into PharmaNet. The FNHA worked closely with Maximus BC, which administers PharmaCare services. As there was no unique client identification across the two different systems, the FNHA had to develop specific codes that could identify clients. The new system however was not able to identify all clients, and information for several thousand clients had to be manually reviewed and matched. Similarly, information on medications and benefits had to be matched between the two systems to ensure continuity of care. Most of this matching was conducted by software while some had to be dealt with manually.

4.4 Introducing Plan W to Clients and Service Providers

At the time of transition, the FNHA undertook an extensive communication program designed to inform First Nations and service providers about upcoming changes, using mailouts, social media, radio advertisements, webinars and in-person meetings and presentations.

This was the first time the FNHA implemented a large-scale communication program targeted at its clients across the province. Given the organization's limited experience in such initiatives, the FNHA created a Working Group on Communications and Engagement within the governance structure for

the transition. The Working Group consisted of six members including senior staff in charge of FNHA's external communication and engagement activities. The objective of the working group was to support the transition process by developing and implementing effective communication strategies and approaches and was supported by the FNHA's Communication team. External contractors were hired to prepare information and communication materials.

The Working Group on Communications and Engagement created and implemented the PharmaCare Communication Strategy to inform First Nations, community representatives and service providers about the upcoming changes. Table 5 provides an overview of the engagement and communication activities undertaken by the FNHA targeted at clients, service providers and other First Nation stakeholders. To reach out to clients, the FNHA used mailout campaigns, social media, website and radio announcements. Two mailouts were sent to individual clients informing them about the transition process. The first mail out (sent in June 2017) provided information about upcoming changes, with the second mail out (sent in September 2017) provided more detailed information about the types of changes that were coming (e.g. instructions for those who travel outside of BC, and accessing drugs provided by agencies). Between 10% and 15% of the letters mailed out were returned (an estimated 15,000 letters) due to incorrect addresses.

The FNHA website and social media platforms (e.g. Facebook, Twitter and Instagram) were used to inform target groups about the changes and provide instructions. The FNHA prepared and posted 134 social media posts related to the transition. The messages were designed to inform clients about upcoming changes and direct them to appropriate sources for more information. Social media posts were adjusted during the transition process to ensure they reflected the most recent highlights about the transition. As part of the social media campaign, the FNHA also created a YouTube video which gathered over 32,700 views during the transition period. Advertisements and announcements were aired on local radio stations to provide information about the changes and the transition. A total of 418 radio announcements were made through three major radio stations during the three-week period prior to the transition.

In addition, in May 2017, representatives of the FNHA met with members of the FNHDA Board of Directors to obtain technical advice on organizing an information campaign for First Nation clients about the upcoming changes. It was agreed that the FNHA will produce information materials and resources, and Health Directors would assist spreading the message at the community level. Based on results of the discussion, the FNHA developed and distributed an extensive list of information materials targeted at service providers and clients. In total, 72,650 information materials, including brochures, instruction sheets, labels, magnets, rack cards, posters and USB memory sticks were produced and placed inside 500 marketing kits. These marketing kits were distributed to 454 locations where First Nation clients gather, including with Health Directors, FNHA nursing stations, regional offices, band offices, hospitals, Aboriginal health centres, Aboriginal Friendship Centers, regional health authorities and pharmacies.

Table 5: Communication and Engagement Activities

Communication Channels	Communication Vehicles	Outputs
Clients		
Mail Campaigns	• Direct Mailouts June 2017 • Direct Mailouts September 2017	• Sent to all First Nation clients • 10% to 15% were returned (an estimated 15,000 letters) due to incorrect addresses
Social Media	• Facebook • Twitter • YouTube • Instagram	• 134 discrete social media posts • 32,700 YouTube views
Websites	• FNHA • PharmaCare • Health Canada	• Regular updates
Media	• Radio	• 3 different stations • 418 radio announcements
Service Providers and other First Nation Stakeholders		
Published Materials	• Marketing kits, including: ➢ Brochure ➢ Brochure stand ➢ Instruction Sheet ➢ Label ➢ Magnets ➢ Mailing addresses ➢ Mints ➢ MOH Rack Card ➢ Poster ➢ USB memory stick	• 500 marketing kits of four different sizes (mini, small, medium, and large) • 28 internal and external communication materials prepared • A total 72,650 information materials were developed and placed inside the 500 marketing kits
Webinars	• Targeted at pharmacists • Targeted at Health Directors • Targeted at all stakeholders including clients	• Two webinars were organized for pharmacists • Two webinars were organized for Health Directors • Eight webinars were organized through UBC Learning Circle
Mail campaigns	• Letters to physicians • Letters to BC Agencies • Letters to First Nation stakeholders	• An introductory letter was sent to 13,000 physicians • Letters were sent to community leaders • Letters were sent to First Nation organizations
Electronic media	• Articles • E-blast • E-newsletter • Websites • Fax-blasts	• Pharmacists were targeted through the BC Pharmacy Association, • Physicians were targeted through Doctors of BC and College of Physicians and Surgeons of BC, • Nurses were targeted through the BC Nurse Practitioners Association
Personal	• In-person meetings • Phone calls • Presentations	• Union of British Columbia Indian Chiefs • FNHDA Board meeting • BC First Nations Summit • Regional Caucus meetings
Training	• In-person training for pharmacists	• Training was delivered to pharmacies in Duncan, Hazelton, Prince George, Prince Rupert and Williams Lake who serve a large number of First Nation clients

To reach out and inform service providers, the FNHA entered into partnerships with professional service delivery organizations (e.g. Doctors of BC, College of Physicians and Surgeons of British Columbia, BC Pharmacy Association, College of Registered Nurses of British Columbia) to use their communication channels. Examples of such partnerships include organizing two webinars, sending fax blasts and distributing information kits and materials to pharmacists through the BC Pharmacy Association. Specific letters were mailed out to approximately 13,000 prescribing physicians through the Doctors of BC and College of Physicians and Surgeons to inform them of upcoming changes and provide them with basic instructions. Articles were also published and distributed through newsletters targeted at physicians, nurse practitioners and pharmacists.

Some pharmacists that serve a large numbers of First Nations clients (e.g. in Duncan, Hazelton, Prince George, Prince Rupert, and Williams Lake) were targeted with information packages, kits, and materials and received specific communications and/or training on addressing client inquiries during the transition. The FNHA also partnered with the MOH to host province-wide meetings to discuss technical changes to the PharmaNet to ensure all registered vendors were able to utilize properly and dispense medications through Plan W. A number of issues related to software were resolved, and by October 1, 2017, all vendors reported that their systems were tested and ready for the transition.

The FNHA communication and engagement activities also targeted representatives of organizations that provide services for FNHA clients (e.g. FNHA nursing stations and health centres, Aboriginal Patient Navigators, Aboriginal liaisons, Assembly of First Nations, NIHB navigators, BC Association of Aboriginal Friendship Centres, FNHDA) and BC Agencies (e.g. BC Transplant, BC Renal Agency, BC Cancer Agency, BC Centre for Excellence HIV/AIDS). These stakeholders were engaged through letters, webinars, phone calls, distribution of marketing kits, articles, newsletters and in-person presentations and meetings. Briefings were sent to the Union of British Columbia Indian Chiefs, and BC First Nations Summit. Personalized letters and information materials were mailed out to First Nations Chiefs and several presentations were made at the FNHDA Board meetings and Regional Caucus meetings.

The communication strategy and approaches were regularly updated to reflect changing project priorities and timelines. For example, the original communications and change management approach was predicated on the premise of "seamless transition" for FNHA clients. However, in May 2017, recognizing a greater potential impact to FNHA clients than originally anticipated, the FNHA increased client focused communications to support transitioning of some FNHA clients to comparable prescription drugs on the PharmaCare formulary and to inform them about the need to fill prescriptions prior to out of province travel. The change required the FNHA to increase focus on client/community communications and engagement, enhance social media outreach, deliver more radio advertisement and support additional training to targeted pharmacies. The FNHA also changed its approach to client mailouts. The second mailout, sent on September 2017, was directed at individual clients rather than households.

Most service providers recalled receiving at least some communication from the FNHA at the time of the transition and regarded communication tools and materials as somewhat effective in helping them to prepare for the transition.

During the survey, all pharmacists (n=26), 75% of nurses (n=8), 71% of Health Directors (n=21) and 67% of physicians (n=9) recalled receiving at least some communication with regards to PharmaCare at the time of transition. Service providers received mostly email instructions and e-

newsletters (85% of pharmacists, 67% of physicians and nurses and 54% of Health Directors) and brochures and printed materials via mail (100% of nurses, 46% of Health Directors, 33% of physicians, and 31% of pharmacists) and participated in webinars related to Plan W (65% of pharmacists, 50% of nurses, 38% of Health Directors, 17% of physicians). In addition, 38% of Health Directors participated in in-person discussions and/or meetings related to the transition.

Service providers found various communication and engagement activities undertaken by the FNHA as somewhat useful in preparing them to the transition. As demonstrated in Table 6, when asked to rate the extent to which communication that they received was useful in helping them prepare for the transition, using a scale 1 to 5, where 1 is not useful at all, 3 is somewhat useful, and 5 is very useful, service providers provided average ratings from 3.0 to 3.4 to indicate that all communication tools and methods (including webinars related to Plan W, in-person discussions or meetings e-mails or e-newsletters, brochures and paper materials and phone discussions or meetings) were somewhat useful. Among service providers, pharmacists were more likely to provide higher ratings compared to ratings provided by other service providers, particularly physicians.

Table 6: Perceived Usefulness of Various Communication Methods

(On a scale of 1 to 5, 1 is not at all useful, and 5 is very useful, how useful was the information you received in helping you prepare for the transition)

	Health Directors (n=14)	Pharmacists (n=26)	Physicians (n=6)	Nurses (n=6)	Total (n=52)
Webinars related to Plan W	2.9	3.8	3.0	3.0	3.4
In-person discussions or meetings	3.0	4.5	2.0	4.0	3.2
E-mails or e-newsletters	3.0	3.4	2.0	3.0	3.1
Brochures and paper materials	3.1	3.1	2.6	3.2	3.1
Phone discussions or meetings	2.7	4.0	1.5	3.5	3.0

Client awareness about Plan W appears low and only a few clients recalled receiving communications from the FNHA with regards to the transition. However, those who received communications from the FNHA regarded it as useful in helping them prepare for the transition.

Among 79 eligible clients who responded to the survey, only 20% (or 16) indicated that they were familiar with Plan W. Among those who were familiar, only 8 (50%) recalled receiving some communication about the Plan W at the time of the transition. Similarly, when asked to rate effectiveness of the FNHA efforts to reach out to and inform clients, using a scale 1 to 5, where 1 is not effective at all and 5 is very effective, service providers (Health Directors, pharmacist, nurses, and physicians) provided an average rating of only 2.4 (n=67) to indicate that those efforts were largely not successful.

Among eight clients who recalled receiving communications related to Plan W, five recalled receiving a letter from the FNHA, four participated in community discussion related to PharmaCare, and two participated in a webinar related to Plan W. Clients also mentioned that they received information from a Health Director, came across information online or through social media and learned about it when the FNHA transition team organized a meeting in their community as part of the Phase 2 of the CPST project transition of the other health benefits. When asked to rate

effectiveness of the FNHA communication and engagement efforts, using a scale 1 to 5, where 1 is not at all useful, and 5 is very useful, clients provided an average rating of 3.9 (n=8) to indicate that the information that they received was useful in helping them prepare for the transition.

Most key informants and survey respondents feel that more work needed to be done to inform community representatives and other First Nation stakeholders about Plan W. They provided a range of recommendations regarding how efforts could be improved in terms of timing, messaging and reach.

When asked about the FNHA efforts to inform BC First Nations in the planning and implementing the transition, about three-quarters of key informants, who expressed an opinion, indicated that more needed to be done. Similarly, survey participants indicate that the FNHA communication and engagement activities needed to be enhanced to better reach out to and adequately inform service providers and clients.

In particular, survey respondents indicate that the FNHA communication and engagement efforts were only somewhat effective reaching out to and informing pharmacists and nurses and mostly not effective in reaching out to and informing Health Directors and physicians.

When asked to rate the effectiveness of the communication and engagement activities in informing service providers about upcoming changes, on a five-point scale where 1 is not at all effective, 3 is somewhat effective, and 5 is very effective: Pharmacists provided an average rating of 3.5, Nurses 2.8, Health Directors 2.2, and Physicians 2.1.

Similarly, when asked to rate the effectiveness of the FNHA in responding to their questions or concerns, pharmacists provided an average rating of 3.2, nurses 2.5, Health Directors 2.4 and physicians 2.1.

The major issues and challenges identified by the key informants and survey respondents include:

- *The timing of the communication activities.* Given the significance of the transition, more time should have been allocated to communication and engagement activities to allow First Nations representatives to learn more about the changes and provide input. According to some key informants, the FNHA should have started the communication activities much earlier or delayed the transition to allow for more time.

- *Messaging and reach.* It is always difficult to inform target groups about upcoming changes, particularly when those changes may or may not affect them. Some key informants note that it was difficult to get the attention of the target groups and help them to understand if and how the transition could impact them as people may not to pay attention to information on program changes until it directly affects them (e.g. when they go to access services). Messaging was also complicated by the following issues:

    - The transition was implemented under tight timelines.
    - Plan W was still evolving and being analyzed to better understand how the transition would impact clients. As a result, the messaging evolved/changed over time.
    - The messaging tended to be positive and focused on potential benefits of the transition, therefore suggesting that most clients would not be affected.
    - Those most affected (e.g. the elderly) tend to be the most difficult group to reach.

- The messaging in letters were generic and did not necessary highlight the impacts relevant to the reader. The letters did not provide sufficient instruction as to what each person should expect and what actions they could take to address their particular issues.

The result was that many clients were simply not aware of changes associated with the transition until it directly impacted them (e.g. they needed to change to therapies or were asked to pay).

- *Design.* Several key informants indicated that the design of materials could have benefitted from input from community representatives or Health Directors and include more visuals.

- *Limited in-person communication*. First Nations communities may often prefer in-person engagement where they can ask questions, have their concerns addressed and build trusting relationships. Key informants and survey respondents note that most communication during the transition was not interactive and happened from a distance, through letters, brochures, webinars, social media.

- *Use of Health Directors to educate community members.* The FNHA met with the Board of Directors of the FNHDA and agreed to work together to inform communities about the transition. During interviews, representatives of the FNHA indicated that they were under impression that based on what was agreed at the FNHDA Board meetings, the FNHA was to develop and provide information materials and tools to the FNHDA and, the Health Directors were to educate community representatives about upcoming changes. The FNHA expected the FNHDA to be a main point of contact for the communication with the communities and take a much greater role in spreading the message and preparing the communities for the transition. However, during the interviews and focus group discussions, Health Directors, felt that:

  - The FNHA should have worked more closely with Health Directors in developing a communication strategy and plan.
  - More should have been done to prepare Health Directors and others to respond to questions received from the community. More information was needed about how the transition would impact clients and service providers, how clients could respond, and how Health Directors could support that process. Community health staff are at the forefront of health and wellness at the community level and receive many requests for clarification and explanation from residents. When community members came to ask questions about Plan W, Health Directors felt that were not able to provide adequate answers.
  - The communication and information materials provided by the FNHA could have been more useful in informing health staff and clients about the changes. Although the materials were informative, they provided no specific instructions on how to help clients navigate the process. For example, most information materials asked clients to consult with their physicians to ensure continuity of the care, when physicians themselves may have lacked an adequate understanding of Plan W.

- *Gaps in reaching out to and informing clients outside of the communities.* A large percentage of First Nation health benefits clients live in urban areas and away from home and the FNHA does not have effective mechanisms to reach out to them. It is difficult to fully understand the extent

to which the communication and engagement activities, implemented at the time of the transition was successful in informing this client group.

FNHA has already addressed some of the challenges experienced during the transition by incorporating some of the key lessons learned into the planning the transition of other health benefits.

Following the transition, the FNHA undertook a number of steps to address issues that arose and improve the activities it is undertaking as part of the Phase 2 of the CPST project transition of the other health benefits. In particular, the FNHA created Community Relations Representative positions across BC to help support FNHA community engagement and communication efforts (one position in each region was created in the Spring of 2018 and all were filled by the Summer of 2018). The scope of the Coordinators covers all health benefits, not just Plan W. They are active in undertaking groundwork to support Phase 2 of the transition. Their role also involves engaging with clients and service providers, and assisting them in navigating Plan W. Over the past year, Coordinators have been extensively involved in organizing community meetings and face-to-face and telephone discussions with pharmacists, physicians and community representatives to support the transition process. One Coordinator reported visiting 150 pharmacists across the region to listen to their concerns and support them in the transition process. Another reported having organized over 30 discussions or in-person meetings with community representatives. Two Coordinators note that they spent approximately 25% of their time working with service providers (e.g. mostly with pharmacists and, to a lesser degree, physicians) and the remainder with community stakeholders.

The timelines for the Phase 2 transition was extended to allow for more extensive engagement. FNHA staff members are travelling across regions and organizing discussions with community stakeholders to inform them about upcoming changes and obtain their perspectives on the Phase 2 transition. In addition, both the FNHDA and FNHC have been involved in the process from the early stages, providing input on program decisions as well as proposed stakeholder and client engagement processes.

5. Results of the Transition – Key Findings

This chapter describes changes in formularies, processes and procedures and drug claims associated with Pharmacy Program as a result of transition and identifies impacts of these changes on clients and service providers.

5.1 Changes to the Formulary and Processes

PharmaCare and the NIHB Program apply different approaches to managing their formularies.

The PharmaCare formulary is managed more actively and updated more frequently then the NIHB Program. PharmaCare carries out its own review before making a drug coverage decision, building on the work of Health Canada and a national Common Drug Review managed by the Canadian Agency for Drugs and Technologies in Health. In its review, PharmaCare undertakes its own research by collecting input from clinicians, residents and manufacturers as well as obtaining a recommendation from the Drug Benefit Council (an independent 12 member advisory committee consisting of nine experts and three members of the public). Considering factors such as efficacy and costs, PharmaCare then may decide to cover the drug in the plan, provide coverage only with a special authority, or not provide the drug at all. Within each category of benefits, PharmaCare focuses on extending coverage to cost-effective drugs that are scientifically-proven to produce similar therapeutic results. The system prioritizes generic drugs which are less expensive than the brand name predecessor and have the same active ingredients, quality and performance.

During interviews, some key informants familiar with the process characterized the approach PharmaCare takes to manage its formulary as robust and scientifically sound. According to these key informants, PharmaCare conducts on-going reviews of available therapies and client needs and extends coverage to most critical benefits that have scientifically proven to produce effective results. The approach enables the program to address client needs in a cost-effective manner and maintain sustainability of the program.

NIHB's policy is somewhat different. The NIHB decisions over formularies are made by the NIHB Drugs and Therapeutics Advisory Committee based on a review by the national Common Drug Review and pan-Canadian Oncology Drug Review. NIHB policy on formularies is to extend coverage to all benefits within the category that are financially affordable and therapeutically acceptable. NIHB formulary excludes drugs and benefits only if they are financially too expensive or therapeutically out-dated.

Reflecting differences in their approaches, the PharmaCare formulary is considerably smaller in size than the NIHB formulary.

The FNHA has developed a Master Formulary List which compiles data on products covered and not covered under the NIHB and PharmaCare formularies[9]. The Master Formulary List includes 63,554 products, which are classified by a standard Drug Identification Number (DIN), a pseudo-DIN number assigned by FNIHB, or by a Product Identification Number (PIN) which is created by PharmaCare to allow claims to be adjudicated by the PharmaNet system. Product Identification Number are created by PharmaCare when a DIN was not supplied by First Databank, a drug or product is classified as an investigational drug or non-pharmaceutical, or the drug or product needs a separate identifier for PharmaCare purposes.

Of the total population of 63,554 products included in the Master Formulary List:

- 8,429 are covered by both PharmaCare and NIHB,
- 685 are covered by PharmaCare only,
- 28,155 are covered by NIHB only, and
- 26,285 are covered by neither.

Appendix I provides a comparative review of the formularies between PharmaCare and NIHB grouped based on the American Society of Health-System Pharmacists (AHFS) Pharmacologic-Therapeutic Tier 1 Classification.[10] As demonstrated in the Appendix, NIHB formulary includes 36,584 products, of which 22,729 are available under prescription and 13,770 are available as OTC.

In comparison, the PharmaCare formulary includes 9,114 products, of which 7,016 are available under prescription, and 1,396 are available as OTC. There are 685 products were are not characterized in the Master Formulary List in terms of availability (they were not identified as OTC or prescription) and are only available through PharmaCare (i.e. are not included in the NIHB formulary). Going through these unknown products on a line-by-line basis, they appear to be relatively evenly divided between those that would be available under prescription and those that would be available over-the-counter.

PharmaCare may also cover an additional 145 products under exceptional circumstances and provides limited coverage for a further 204 products. Limited coverage drugs are not generally considered to be first-line therapies or there are more cost-effective alternatives. To be eligible for coverage of these drugs, the patient must meet criteria pre-defined by PharmaCare.

While the number of products of products listed in the NIHB formulary is much larger, it should be noted that:

- Under the NIHB formulary list, many items are not manufactured drugs and therefore do not have a formal DIN number. The NIHB Program assigns a pseudo-DIN number to include these items/supplies in their formulary list.

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9 Formularies evolve over time. This section is based on an analysis using a source file data dated August 7, 2018.

10 AHFS classifications are used to organize drug formularies in institutional, governmental, and other settings. The AHFS classification groups drugs with similar pharmacologic, therapeutic, and/or chemical characteristics in a four-tier hierarchy.

- Different regions within FNIHB may have assigned different pseudo-DINs (pDINs) numbers to the same drug. As a result, one drug may have multiple numbers within the NIHB formulary.

As a result, the NIHB statistics likely overstate the number of unique products in the formulary. More importantly, the impact of having a much greater number of benefits within the NIHB Program formulary relative to PharmaCare is reduced by the fact that a small number of benefits (i.e. DINs/PINs) accounted for the majority of claims under the NIHB Pharmacy Program. For example, in the 12 months prior to the transition, approximately 2.6 million claims were made in BC totalling nearly $80 million. Of the more 36,000 DINs/PINs listed in the NIHB Formulary, 18 DINs (only 0.05% of the DINs in the formulary) accounted for 25% of the total value of the claims, 149 (0.4%) accounted for 50% of the claims, and 737 (2%) accounted for 75% of the claims.

Nevertheless, the difference in formularies can result in individuals having to switch their therapies.

PharmaCare provides coverage under each of the major drug classes (as defined in AHFS Tiers 1, 2 and 3) but may not provide the same selection of products covered under NIHB. This could result in some individuals having to:

- Switch from one product to another. That could include switches from one name brand to another, from brands to generics, or from one generic to another generic.
- Switch from combination products (where two drugs are combined into one) to two separate products (or vice versa, an individual who was previously using two products may have been switched to a single product).
- Receive the product in a different product form (that is, the same therapy is continued but the product is not the same; for instance, a change from a cream to an ointment).
- Accept a change in dosage. Difference dosages of the same product may result in widely varying costs. Two examples are Ramipril (ACE inhibitor) and Paroxetine (anti-depressants). In these cases, the NIHB formulary covers three strengths of capsules whereas PharmaCare covers only two. As indicated, the cost per milligram of the active ingredient varies widely across the dosages.

Table 7: Examples of Coverage and Cost Depending on Dose of Same Therapy

Drug Dosage	NIHB coverage	Plan W Coverage	Cost	Cost Per 10mg
Paroxetine 10mg	Y	N	$1.403 per tablet	$1.40
Paroxetine 20mg	Y	Y	$0.325 per tablet	$0.16
Paroxetine 30mg	Y	Y	$0.3453 per tablet	$0.12
Ramipril 5mg	Y	Y	0.0817 per capsule	$0.16
Ramipril 10mg	Y	Y	$0.1034 per capsule	$0.10
Ramipril 15mg	Y	N	$0.855 per capsule	$0.57

Source: Summary of Plan W vs NIHB Coverage of Paroxetine Hydrochloride and Ramipril (February 19, 2019)

The transition also resulted in other notable changes in terms of how pharmacy benefits are delivered to First Nations clients in BC related to shifting to a first payer system, the ability to access benefits out of province, processes for appeal and special authorities and access to emergency supplies.

The most significant changes from the transition are as follows:

- *Shift to first payer position*. In the interviews with key informants, a commonly identified advantage of Plan W over how pharmacy benefits were provided under the NIHB Program relates to its first payer position. In 2013, when the FNHA held discussions with Health Directors and community members, one of the important recommendations was to move from a 'provider of last resort' (i.e. when clients are eligible for coverage under other plans, claims must be submitted to these plans first) into a 'provider of first resort.' Consequently, at the time of transition, the FNHA conducted internal analysis to determine potential impacts (e.g. financial and accessibility) of the shift. Based on the results of the analysis, the decision was made to ensure Plan W be the first payer for FNHA clients at the pharmacy counter.

- *Access to coverage out of province*. Accessing drugs while traveling out of province became more difficult as PharmaCare is not designed to provide coverage outside of the province. When outside the province, clients commonly have to pay for their medication in advance and receive reimbursement. However, not all clients can afford prepayment and some BC First Nations residents located in communities close to the Yukon or Alberta borders have commonly purchase their therapies from pharmacies in neighbouring jurisdictions

  To ease this issue, the FNHA has implemented an emergency measure and sometimes charges the cost of medication on credit cards when pharmacies outside of the province phone in a prescription. The measure is temporary, and at the time of this evaluation, it was used only in emergency situations. Key informants suggested that the FNHA will need to come up with a more effective long-term solution to the issue.

- *Changes in benefits resulting from the Reference Drug Program (RDP) and the Low Cost Alternative (LCA) Pricing Policy*. Introduced in 1995, RDP is a PharmaCare policy to encourage cost-effective first-line prescribing for common medical conditions. The RDP groups drugs into categories with a similar therapeutic application but different active ingredients. Within a RDP category, there are designated reference drugs and non-reference drugs. Among the reference drugs, one drug is selected as the reference drug comparator, which sets the reference price for the non-reference drugs. Full coverage, subject to the usual PharmaCare plan rules, is provided for all the drugs established as reference drugs, including the reference drug comparator. Partial coverage up to the reference price is provided for the non-reference drugs in the category. This rule ensures that when more than one drug is available to treat a condition, PharmaCare will pay for the one that costs the least (i.e. the "reference drug") where there is evidence that it is as effective as the higher-cost option. FNHA clients previously on non-reference RDP drugs were grandfathered with special authority. However, new claims would be subject to RDP.

  LCA groups generic drugs that contain the same active ingredients in the same strength and formulation into categories. PharmaCare assigns a maximum price it will cover for all the products in the category. Each category contains one or more brand name versions of the drug

and all of the generic versions priced at or below the PharmaCare maximum price. PharmaCare fully covers drugs priced at or below the maximum price for their category. PharmaCare does not normally cover generic drugs that are priced above the maximum price for their category and they are not listed in the PharmaCare formulary. PharmaCare partially covers brand name drugs that are priced above the maximum price for their category—up to the maximum price for the category. No such requirement exists for the NIHB Program. After the transition clients were subject to LCA, indicating that some were required to change their medication from name brands to generic brands or pay-out-of-pocket for the difference.

- *Changes in prior approval/special authority processes*. NIHB has a prior approval program for drugs of concern (e.g. high-cost drugs, drugs that can be abused, drugs with narrow therapeutic index). PharmaCare has a special authority process for drugs that they cover only for specific indications. A few key informants commented that the process of issuing special authorities has become much more streamlined under Plan W. In the past, prior approvals were initiated by pharmacists who had to coordinate between physicians, the NIHB Program and clients. The process required several steps and back-and-forth communication using fax and telephone calls. The system could break down at any of a number of stages.

  Under Plan W special authorities are initiated by physicians and the steps required for approval (and the time it takes) has been reduced and streamlined. Furthermore, physicians receive immediate notification on the status of the special authority and are aware if the prescription is filled (under NIHB, physicians would not know the status unless they contacted pharmacists or clients). Finally, under PharmaCare, when a special authorization is approved for one drug of the group, it is extended automatically to all drugs in that group. NIHB has no such system and prior approvals had to be obtained for each specific benefit regardless of their grouping.

  While there are some advantages, service providers also note a number of disadvantages associated with PharmaCare's process for special authorities:

  - The process creates more work for the physician.
  - Pharmacists are often unaware when the requests are approved (unless informed by a physician) and therefore are not able to notify clients.

  At the time of the transition, the number of applications for special authorities increased significantly. The increase was partially due many clients not wanting to change their therapies, and applying for special authorities to be able to continue therapies that they used prior to the transition. Although data is not available,[11] according to key informants and survey respondents, many of these special authorities were rejected because Plan W had alternative benefits with similar therapeutic qualities in its formularies. PharmaCare rules indicated that in these circumstances, special authorities are approved only when therapies covered by the program have shown to be ineffective or generate adverse conditions. Consequently, of those surveyed, almost 60% of pharmacists and about one-half of Health Directors, physicians and nurses indicated that processes used to review and approve special authorities/prior approvals have become more difficult since the transition.

[11] PharmaCare does not track approval rates for special authorities.

- *Changes in appeal processes and procedures.* The NIHB Program had a three-level appeal process. When the FNHA assumed the delivery of the pharmacy benefits, it signed an agreement with FNIHB allowing the third (final) stage of the NIHB appeals to be adjudicated by the FNHA.

  PharmaCare has no formal appeal process. However, there is no limit on how many times a physician can resubmit a request for special authority as long as they are able to provide additional justification. In addition, clients or service providers can contact PharmaCare request an 'exceptional review'.

  The FNHA does offer an official three stage appeal process which allows clients or caregivers to appeal Plan W decisions directly to the FNHA. However, both awareness of this option and probability of success appear to be very low. Since the transition, only 38 appeals have been submitted to the FNHA, of which only one (3%) was approved as an exception. Other appeals were denied because alternative benefits with similar or better therapeutic qualities were available in Plan W formularies. Consequently, clients who participated in the surveys provided an average rating of 2.3 (on a scale 1 to 5, where 1 is strongly disagree and 5 is strongly agree, n=44) to indicate that they found it difficult to appeal claims rejected under Plan W. Similarly, 43% (n=23) of Health Directors, nurses and physicians who had an answer reported that the transition made it more difficult for them and clients to appeal the decisions, while only 9% indicated that the appeal process have become easier under the new system, and 48% indicated no impact in this area.

- *Access to emergency supplies and medication*. NIHB allowed pharmacists to dispense an emergency supply of a new medication requiring special authorization (i.e. prior-approval) when authorization cannot be obtained in a timely manner (the maximum amount allowed to dispense was a seven day supply). PharmaCare does not fund pharmacists to dispense emergency supplies of a new medication, although existing medications used to treat chronic conditions are eligible for the maximum emergency supply of 14 days.

The FNHA undertook various analyses of the potential impact of the transition on clients and implemented a number of important steps in advance to address anticipated issues.

The FNHA was largely viewed by key informants as effective in identifying and responding to particular issues and challenges that arose during implementation of the transition. For example, prior to the transition date, the FNHA conducted a comparative analysis of the formularies, processes and procedures employed by NIHB and PharmaCare. Eighty-one differences were identified and discussed within working groups and the FNHA leadership to identify changes that could have a significant impact on clients. A plan of action was developed and implemented to address those issues. Some of the major actions undertaken by the FNHA to address issues that were identified include:

- *Access to OTCs was increased by having items added into the Plan W formulary and providing temporary coverage through the NIHB Program*. Prior to the establishment of Plan W, very few OTCs were covered under PharmaCare. In attempting to address this issue, the FNHA first negotiated with FNIHB to continue coverage in BC for OTC benefits. However, largely because of some concerns regarding technical issues, FNIHB decided that it could not provide that coverage in BC. The FNHA transition team responded by (1) working with PharmaCare to add nearly 1,400 OTC medications into the Plan W formulary; and (2) working with FNIHB to establish a residual list that provides temporary coverage through NIHB for selected items that

could not be covered by PharmaCare. As of August 2018, the residual list included about 850 products including 95 products that are classified as drugs (under AHSF Tier 1 and Tier 2); the remaining products on residual list include supplies such as pressure garments, orthoses, orthotic supplies, mobility aids, and wound dressings and bandages. Coverage for most of these items will be provided as part of the Phase 2 transition.

Table 8: Products Included in the NIHB Residual List

Description		Number
By AHSF Tier 1 and 2		
AHSF1	**AHSF2**	
Antihistamine drugs	Second generation antihistamines	3
Anti-infective agents	Antivirals (systemic)	1
Autonomic drugs	Autonomic drugs, miscellaneous	23
Central nervous system agents	Analgesics and antipyretics	1
	Anxiolytics, sedatives and hypnotics	6
	Opioid antagonists	7
Eye, ear, nose and throat (EENT) preps.	Antiallergic agents	10
	Anti-infectives (EENT)	11
	Anti-inflammatory agents (EENT)	6
	EENT drugs, miscellaneous	4
Hormones and synthetic substitutes	Adrenals	1
	Contraceptives	7
	Estrogens and antiestrogens	4
Respiratory tract agents	Anti-inflammatory agents (respiratory)	1
Skin and mucous membrane agents	Anti-infectives (skin, mucus membrane)	10
	Skin and mucous membrane agents, misc.	4
Vitamins	Vitamin D	6
Sub-total		95
Not Identified By AHSF		
Pressure garments, orthoses, orthotic supplies		269
Mobility aids		141
Undefined & unknown		97
Wound dressings & bandages		60
Other		52
Hearing aids		41
Oxygen supplies and equipment		40
Incontinence supplies and toileting aids		16
Feeding aids		14
Vision aids		13
Syringes		4
Ostomy supplies & devices		3
Breast pumps		2
Total		752
Grand Total		**847**

During the first year after the transition, claims for the products included on the residual list totalled about $2.1 million, which represents about 2.5% of the total value of the claims made.

- *The call centre was expanded*. The transition generated much larger volumes of calls than expected. This was partially because the call centre was a key component of the FNHA

communication activities at the time of the transition. Letters sent to clients, pharmacists and physicians and other partners asked recipients to contact the FNHA through a toll-free number if they had questions or concerns regarding Plan W. The number of incoming calls received peaked at 444 during the first week of the transition. Fifty-two percent of calls came from service providers, 39% came from clients and 9% came from other stakeholders who had questions or were looking for assistance. Most calls related to issues such as obtaining special authorities, being asked to pay for certain therapies or services or being able to access medications while outside of the province.

The number of incoming calls was much greater than what the FNHA call centre had the capacity to handle. Consequently, wait times for calls were very high. During the first week of the transition, the median wait time was 52 minutes; of the 444 incoming calls, 39% were abandoned, only 13% were answered, and about half (44%) received call-backs. In addition to the long wait times, key informants also note that most call centre staff had only recently been recruited and were still becoming familiar with Plan W themselves, and therefore were not always able to address customer issues adequately. Furthermore, the newly created data warehouse at the FNHA did not initially have an integrated client search portal, which meant that call centre staff had to extract client data manually to assist with client inquiries. The FNHA responded to the problem by triaging more staff immediate, helping stabilize the situation.

As the transition rolled out, the number of calls declined, the FNHA responsiveness to calls improved and the call centre staff became more knowledgeable. Reduced volumes, combined with increased capacity (i.e. more call centre staff), enabled average wait times and abandoned calls to decline sharply. By the end of October 2017, median wait times averaged 2 to 4 minutes; 15% of the calls were abandoned while 76% were answered and 3% received a callback. At the same time, the technical capabilities were expanded and the client search portal became operational.

The FNHA conducts a satisfaction survey with its clients through its website. Clients are provided an opportunity to fill out the survey each time they come into contact with FNHA services. A review of the survey results demonstrates there was a significant decline in client satisfaction indicators during the first three months of the transition. For example, the percentage of clients reporting that it was easy to get in contact with an FNHA representative declined from 41% (n=225) prior to the transition date to 30% (n=32) at the time of the transition (from October 1, 2017 to December 31, 2017). The percentage of respondents who indicated that a FNHA representative on the phone was knowledgeable declined from 42% to 10% during the same time period. As demand eased and the capabilities of the call centre were strengthened, satisfaction levels improved. Of the 294 clients who completed the satisfaction survey between January 2018 and October 2018, 41% indicated that it was easy to get in contact with a representative of FNHA and 39% indicated that FNHA representative on the phone was knowledgeable about their issues.

- *Various technical issues were addressed.* During the very early days of the transition, some benefits were denied due to technical issues. For example, through an error, some OTC items were not added into Plan W. There was a technical glitch in the MOH PATCOB Router (the gateway appliance that determines if a client's drug claim should be adjudicated by PharmaNet or re-directed to other programs such as NIHB) which resulted some client claims being rejected. According to key informants, PharmaCare and the FNHA worked closely and effectively to address any technical glitches within the first several weeks of the transition.

In addition, some point-of-sale systems at the pharmacy level were not operating correctly because local cashiers had hard-coded some fields (as a time-saving technique) which impacted on the system updates. Working closely with partners, the FNHA figured out the issue and leveraged MOH and the PharmaNet software vendors to ensure pharmacies adopted the appropriate practices with their respective point-of-sale systems.

- *FNHA initiated Transitional Coverage Request (TCR) Form.* TCRs facilitate access to emergency medication for clients. The form can be filled by a pharmacist when a benefit is declined due to technical or other reasons. By using the TCR forms, pharmacists are able to provide coverage and receive funding for the medication from the FNHA at a later date. Between October 2017 and September 2018, 1,299 TCRs were used to process claims. During interviews, pharmacists note that the TCRs have been very effective in ensuring coverage and continuity of care. However, use of the TCR increases administrative work for pharmacists related to completing and submitting the forms and processing payments from the FNHA. Use of TCRs may vary across pharmacists depending upon their familiarity with the process and willingness to undertake the extra administrative work.

- *Staffing was increased.* The FNHA created nine new positions as part of the operations team. Most transition and operations team members worked extended hours during the transition to address the issues and challenges and to ensure clients were provided with adequate coverage and benefits.

- *The FNHA followed-up with pharmacists and clients in areas where issues have been identified or are most likely to occur.* In order to ensure the system is functioning well, the FNHA has placed a priority on reaching out to pharmacists who were most likely impacted (i.e. they serve a large number of First Nations clients) or where issues have been identified (e.g. the FNHA has received calls from clients dealing with a particular pharmacy on issues that could have addressed at the pharmacy level). In addition, the FNHA has continued its partnership with the BC Pharmacy Association to deliver training and provide support for pharmacists.

5.2 Changes in Claims

The number of BC First Nations receiving pharmacy benefits through the FNHA increased by 2% in the year after the transition, which is significantly higher than the average annual increase in the four-year period prior to the transition.

The number of BC First Nations claimants for pharmacy benefits totalled 101,101 in 2017/18, which represents an increase of 2.0% over 2016/17. The average annual increase in the number of claimants over the previous four years was 0.1%.

Table 9: Total Number of Unique Claimants By Program – Pharmacy

Program	2012 - 2013	2013- 2014	2014 - 2015	2015 - 2016	2016 - 2017	2017/- 2018
Claimed through NIHB	98,725	97,020	98,710	98,466	99,096	26,957
Claimed through PharmaCare	0	0	0	0	0	89,904
Total Unique Claimants[12]	98,725	97,020	98,710	98,466	99,096	101,101
Annual Growth Rate		-1.7%	1.7%	-0.2%	0.6%	2.0%

Source: FNHA Data Warehouse (FNHADW) Enrolment Data (extracted February 2019),

Of the 101,101 claimants, 73% had claims submitted under Plan W only, 11% had claims submitted under NIHB only, and 16% had claims submitted under both Plan W and NIHB during the course of the year.

There were significant increases in pharmacy benefits delivered to BC First Nations across a range of key metrics, and the rate of increase was greater compared to the average annual increase in the four-year period prior to the transition.

Table 10 summarizes data on the number of claimants, claims and total expenses by wellness area for the past six years. During the first year of Plan W operation, there were increases across each of the key metrics reported in the table including:

- The number of claims increased from 2.63 million to 2.82 million (an increase of 7.2%; the increase over the previous four years averaged 2.4% annually).
- The average number of claims per claimant increased from 26.6 to 27.9 (an increase of 5.1%; the increase over the previous four years averaged 2.3% annually).
- Expenditures on claims increased from $79.6 million to $88.1 million[13] (an increase of 10.8%; the increase over the previous four years averaged 6.4% annually).
- Average expenditures per claim increased from $30.23 to $31.23 (an increase of 3.3%; the increase over the previous four years averaged 3.9% annually).
- Average expenditures per claimant increased from $802.97 to $871.66 (an increase of 8.6%; the increase over the previous four years averaged 6.3% annually).

The only wellness area for which the value of claims declined was opioids for pain management. Of the $88.1 million in claims, $7.3 million (8%) was claimed through NIHB while $80.8 million (92%) was claimed through PharmaCare. Three categories of drugs (central nervous system agents, anti-infective agents, and hormones and synthetic substitutes) accounted for over 50% of NIHB claims.

[12] The number of total unique claimants is lower than the sum of patients from NIHB and Plan W, as some patients claimed through both programs.

[13] Expenditures on claims does not include $6,519,599.05 in rebates that FNHA received in 2016/17 fiscal year, and $12,134,867.02 in rebates it received in 2017/18 fiscal year from drug manufacturers as part of the Product Listing Agreement.

Table 10: Number of Claimants, Claims and Total Expenses By Wellness Area

Program	2012 - 2013	2013 - 2014	2014- 2015	2015 - 2016	2016- 2017	2017 - 2018
Number of Claimants						
Chronic Disease & Prevention	40,899	40,356	41,114	42,145	43,265	43,138
Hepatitis C Antivirals	73	62	120	173	191	263
Mental Health & Wellness	24,160	23,804	24,196	25,021	25,323	26,103
Opioids for Pain Management	29,655	29,328	27,655	26,512	24,287	22,880
Other	93,111	91,244	92,736	92,334	92,643	93,935
Total	**98,725**	**97,020**	**98,710**	**98,466**	**99,096**	**101,101**
Number of Claims						
Chronic Disease & Prevention	535,609	548,592	572,421	603,102	625,268	671,419
Hepatitis C Antivirals	475	729	1,384	2,388	1,809	2,302
Mental Health & Wellness	533,574	494,082	545,951	573,264	607,189	702,594
Opioids for Pain Management	208,516	236,503	203,355	187,922	165,329	149,919
Other	1,112,137	1,136,432	1,169,046	1,216,187	1,232,374	1,295,987
Total	**2,390,311**	**2,416,338**	**2,492,157**	**2,582,863**	**2,631,969**	**2,822,221**
Average Claims Per Claimant						
Chronic Disease & Prevention	13.1	13.6	13.9	14.3	14.5	15.6
Hepatitis C Antivirals	6.5	11.8	11.5	13.8	9.5	8.8
Mental Health & Wellness	22.1	20.8	22.6	22.9	24.0	26.9
Opioids for Pain Management	7.0	8.1	7.4	7.1	6.8	6.6
Other	11.9	12.5	12.6	13.2	13.3	13.8
Total	**24.2**	**24.9**	**25.2**	**26.2**	**26.6**	**27.9**
Total Expenditures ($)[14]						
Chronic Disease & Prevention	$20,541,188	$20,415,557	$21,401,022	$22,810,561	$24,635,679	$26,971,572
Hepatitis C Antivirals	$632,562	$824,149	$6,519,613	$10,537,772	$10,161,889	$13,514,543
Mental Health & Wellness	$8,976,748	$9,065,028	$9,706,417	$10,520,412	$11,828,608	$13,129,418
Opioids for Pain Management	$4,362,636	$4,461,098	$4,019,811	$3,736,324	$3,363,035	$3,182,236
Other	$27,554,294	$27,156,074	$28,249,434	$28,710,189	$29,582,148	$31,328,123
Total	**$62,067,428**	**$61,921,906**	**$69,896,298**	**$76,315,257**	**$79,571,360**	**$88,125,892**
Average Expenditures Per Claim ($)						
Chronic Disease & Prevention	38.35	37.21	37.39	37.82	39.40	40.17
Hepatitis C Antivirals	1,331.71	1,130.52	4,710.70	4,412.80	5,617.41	5,870.78
Mental Health & Wellness	16.82	18.35	17.78	18.35	19.48	18.69
Opioids for Pain Management	20.92	18.86	19.77	19.88	20.34	21.23
Other	24.78	23.90	24.16	23.61	24.00	24.17
All	**$25.97**	**$25.63**	**$28.05**	**$29.55**	**$30.23**	**$31.23**
Average Expenditures Per Claimant ($)						
Chronic Disease & Prevention	502.24	505.89	520.53	541.24	569.41	625.24
Hepatitis C Antivirals	8,665.23	13,292.73	54,330.11	60,911.98	53,203.61	51,386.10
Mental Health & Wellness	371.55	380.82	401.16	420.46	467.11	502.99
Opioids for Pain Management	147.11	152.11	145.36	140.93	138.47	139.08
Other	295.93	297.62	304.62	310.94	319.31	333.51
All	**$628.69**	**$638.24**	**$708.10**	**$775.04**	**$802.97**	**$871.66**

Source: FNHADW Enrolment Data (extracted February 2019)

[14] Expenditures exclude rebates that the FNHA's Pharmacy Program received from drug manufacturers as part of the Product Listing Agreement. These agreements are volume based; the more program spends on a given drug in a year, the greater the rate of rebate provided. For example, the total amount of rebates received was $874,307.68 in 2013/14, $1,616,806 in 2014/15, $6,610,719 in 2015/16, $6,519,599 in 2016/17 and $12,134,867 in 2017/18.

Table 11 provides a summary of purchases of selected drugs by leading AHFS Tier 3 categories during the 12 months prior to the transition and the 12 months after. As indicated, the value of claims in each of the categories increased in the year after the transition.

Table 11: Comparison of the Value of Claims By AHFS Tier 3 in the Years Pre and Post Transition

Leading Tier 3s (Over $500,000 in Value)	Pre-Amount	Post-Amount	Change
HCV Antivirals	$ 7,646,600	$ 12,321,236	$4,674,636
Disease-Modifying Antirheumatic Agents	$ 6,924,233	$ 8,962,671	$2,038,438
Opioid Agonists	$ 4,245,222	$ 5,118,510	$873,288
Antipsychotic Agents	$ 3,328,671	$ 4,659,497	$1,330,826
Antidepressants	$ 3,089,323	$ 3,195,641	$106,318
Corticosteroids (Respiratory Tract)	$ 2,280,676	$ 2,612,389	$331,713
Insulins	$ 2,168,639	$ 2,672,202	$503,563
Anticonvulsants, Miscellaneous	$ 1,878,685	$ 1,977,138	$98,453
Proton-Pump Inhibitors	$ 1,720,848	$ 1,758,187	$37,339
Antineoplastic Agents	$ 1,314,977	$ 1,483,883	$168,906
Angiotensin-Converting Enzyme Inhibitors	$ 1,286,521	$ 1,309,532	$23,011
Nonsteroidal Anti-Inflammatory Agents	$ 1,137,144	$ 1,538,986	$401,842
Contraceptives	$ 1,115,222	$ 1,261,197	$145,975
HMG-COA Reductase Inhibitors	$ 1,072,013	$ 1,188,088	$116,075
Diabetes Mellitus	$ 966,622	$ 1,119,721	$153,099
Second Generation Antihistamines	$ 911,845	$ 1,025,776	$113,931
Dipeptidyl Peptidase-4(Dpp-4) Inhibitors	$ 867,321	$ 871,679	$4,358
Opioid Partial Agonists	$ 819,198	$ 871,716	$52,518
Penicillins	$ 693,873	$ 725,002	$31,129
Anticoagulants	$ 647,937	$ 930,756	$282,819
Beta-Adrenergic Blocking Agents	$ 629,552	$ 819,838	$190,286
Beta-Adrenergic Agonists	$ 619,370	$ 699,281	$79,911
Skin and Mucous Membrane Agents, Misc.	$ 610,267	$ 798,130	$187,863
Anti-Inflammatory Agents (Skin, Mucous)	$ 592,296	$ 619,207	$26,911
Dihydropyridines	$ 562,514	$ 660,849	$98,335
Biguanides	$ 500,560	$ 592,883	$92,323
Cephalosporins	$ 488,068	$ 531,585	$43,517
Immunomodulatory Agents	$ 473,556	$ 593,887	$120,331
Autonomic Drugs, Miscellaneous	$ 460,656	$ 634,002	$173,346
Antimuscarinics/Antispasmodics	$ 456,342	$ 566,981	$110,639
Histamine H2-Antagonists	$ 374,961	$ 533,934	$158,973
Iron Preparations	$ 351,295	$ 527,781	$176,486
Vitamin D	$ 241,841	$ 502,279	$260,438

Source: FNHA Year 1 Pre and Post Comparison Data

Each of these categories may consist of a range of different products, which may, for example, be produced by different manufacturers or may involve different dosages or different product forms. Appendix II provides a more detailed summary of the expenditures on claims for selected drugs (grouped by leading DIN/PIN numbers). The listed products involved over $250,000 in claims in either the year prior or the year after transition. As indicated, 9 of the 43 products saw a reduction in claims. The decline was most significant for Harvoni and Sovaldi (both of which are HCV Antivirals) and Cymbalta (an antidepressant). Harvoni and Sovaldi are covered PharmaCare but require a special authority. Cymbalta (duloxetine) was not initially available under PharmaCare for any new starts after October 1, 2017, however, as of December 2017, Cymbalta is now listed in PharmaCare although it requires a special authorization for new starts.

Two benefits that have experienced the most significant increase in claim amounts include Epclusa (increase by $5.7 million), and Zepatier (increase by $1.3 million) both of which are used in the treatment of Hepatitis C.

Overall claims and expenditures on diabetes drugs and test strips increased in the year after transition. However, the data indicates that there was there was considerable switching between products within the diabetes drugs category.

Diabetes was identified by key informants and focus group participants as the drug category that is most impacted by the transition to Plan W. A review of the administrative data related to both insulin and non-insulin diabetes drugs indicates that, during the first year of Plan W, the number of claims for diabetes drugs increased from 111,209 to 119,744 (an increase of 7.7%; the increase over the previous four years averaged 6.8% annually); expenditures on claims increased from $4.97 million to $5.24 million (an increase of 5.4%; the increase over the previous four years averaged 11.1% annually); and average expenditures per claimant decreased from $44.70 to $43.76 (a decrease of 2.1%; the increase over the previous four years averaged 4.0% annually).

Although overall claims increased, there was considerable shifting between products in the anti-diabetes category. Appendix III provides a comparative review of the value of claims for the 142 diabetes drugs in the year prior to and year after the transition. Of the 142 anti-diabetes drugs, 36 are included only in the NIHB formulary (clients may have been covered under special authorities after the transition) while 106 are covered by both programs. A comparative review demonstrates that, of the 142 anti-diabetes drugs for which claims were processed, 69 experienced a decrease in claim amounts and 73 experienced an increase. The drugs that experienced the most significant decrease in claim amounts were the ones that were not included in PharmaCare formulary, particularly Januvia and Janumet, both of which are Dipeptidyl Peptidase-4(Dpp-4) Inhibitors.

At the time of the transition, the FNHA conducted an analysis of the formularies between PharmaCare and NIHB and estimated that approximately 350 clients who used Januvia and 450 clients who used Janumet would be affected by the transition. As the PharmaCare did not provide coverage for these medications, clients who were in Januvia and Janumet and those in other drugs in the same class (DDP4 inhibitors) were issued special authorizations for a six-months period, while providers were instructed to switch to a covered therapy. From the claims data, it appears most likely that clients were transitioned into Trajenta and Jentadueto.

Diabetes test strips were also identified by key informants and focus group participants as an area of concern. It was suggested that limits on the number of test strips are lower under PharmaCare

that they were under NIHB. However, available information suggests that the limits are not significantly different as summarized in the following table.

Table 12: Blood Glucose Test Strips Coverage

Management	PharmaCare (strips/yr)	NIHB (strips/yr)
Diet/Lifestyle alone (no drugs)	200	200
Drugs with low hypoglycemia risk: Acarbose, metformin, DPP4is, GLP1 agonists, SGLT2s, TZDs	200	200
Drugs with higher hypoglycemia risk: Sulfonylureas, repaglinides	400	400
Insulin	3,000 (8.2 strips/d)	500/100 days (5/d)

Source: Diabetic Supplies One Pager, provided by the FNHA

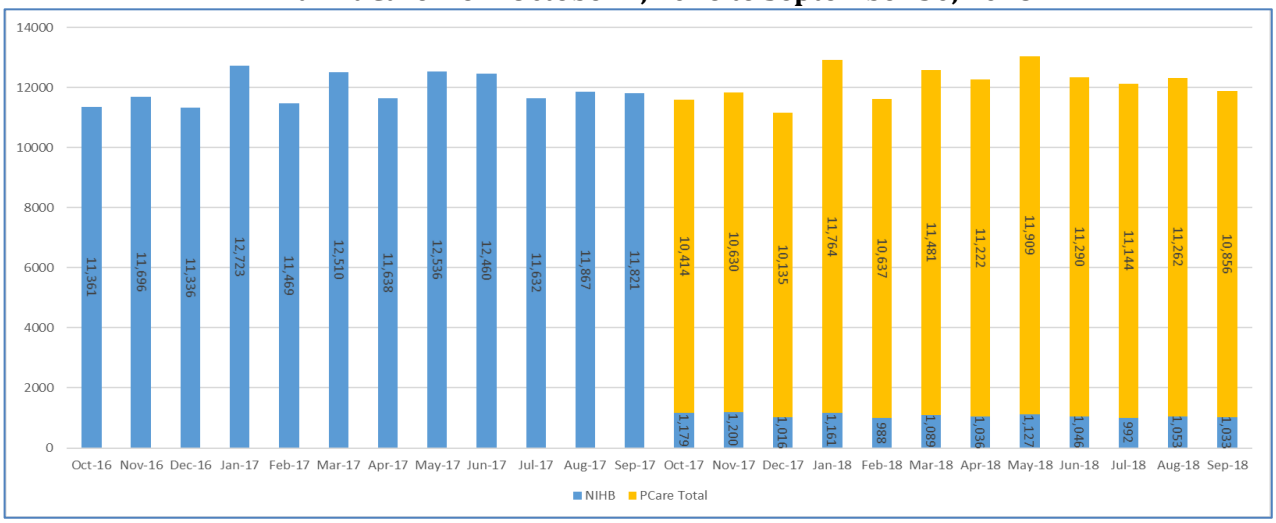
Furthermore, it appears that claims and total expenditures associated with the test strips have been increasing since the transition. A review of administrative data indicates that claims for strips increased in the year after the transition by 6% (from 3,745 to 3,961), days supply increased by 12% (from 324,542 as to 362,704 days), and claim expenditures increased by 16% (from $966,622 to $1,119,721).

Claims data indicates that, overall, the number of clients with paid OTC claims has not changed significantly since the transition.

Historically, PharmaCare has not provided significant coverage for the OTCs. Under Plan W, the FNHA has been able to provide coverage by having medications added to the formulary (there are nearly 1,400 OTC medications now covered through PharmaCare) and by negotiating with FNIHB to extend temporary coverage items in the NIHB residual list.

Figure 1 summarizes the number of claims for OTC medications submitted to NIHB for the year prior to October 1, 2017, and to NIHB and PharmaCare during the year after. The number of claimants remained relatively stable: there were 41,811 distinct clients with paid claims from October 1, 2016, to September 30, 2017, compared to 41,759 distinct clients with paid claims from October 1, 2017, to September 30, 2018. Since the transition, most OTC claimants made their claim through Pharmacare. During the first year after the transition, 4,876 distinct clients claimed for OTC medications through NIHB while 38,178 distinct clients claimed through PharmaCare.

Figure 1: Number of Clients with Paid Claims on OTC Items in NIHB and PharmaCare from October 1, 2016 to September 30, 2018.



Source: OTC Claim Summary Report

There are also examples where the transition has created new opportunities for clients.

Under the NIHB Program, ostomy supplies are considered medical supplies and prior approval is required. However, ostomy supplies are more accessible via PharmaCare as no prior approval is required and these were included in Plan W. This alleviates some pressure in the health care system as FNHA clients no longer need to go to the emergency room to obtain the supplies. As a result, there is a significant increase in the number of clients with paid claims for ostomy supplies following the transition period.

The impact of the change in formulary needs to continue to be closely monitored to validate findings and attribute the increase in utilization to any particular area of the programming.

Given the limitation of the evaluation, it is difficult to attribute the increase in utilization of pharmacy benefits to any area of the program activities or design. However, the move from 'a provider of last resort' to a first payer position, may have contributed, at least in part, to increase in pharmacy benefits delivered to clients through the FNHA's Pharmacy Program. At the time of the transition, the FNHA conducted extensive analysis and estimated that a switch to 'first payer model' may increase program expenditures up to $6 million within first few years of the transition. In addition, during discussions, several key informants note that more streamlined services under PharmaCare may have contributed to an increase in utilizations and a rate of growth in program expenditures. However, more analysis should be conducted to validate these findings.

Furthermore, at the time of the transition, the FNHA issued over 110,000 transitional special authorities allowing some clients to continue receiving the same medication that they received under the NIHB. At least 78% of these special authorities were indefinite. However, 22% required renewal within 4 to 12 months period (15% were to expire in four months, 6% were to expire in six months, and 1% were to expire in 12 months). Clients who had their special authorities expire could renew (except for the Januvia DPP4 drug class).

5.3 Impact on Clients

The transition has enabled the FNHA to develop a strong partnership with the provincial government that should enable it to influence Plan W formularies in the future. Some changes have already been made to Plan W benefits and the FNHA is working with PharmaCare to include additional First Nations specific benefits.

Key informants suggest that, now that pharmacy benefits are administered from BC rather than nationally, it will become much easier for the FNHA to affect the policies, formularies and pharmacy benefits provided. Under the NIHB Program, it was difficult to affect the benefits because decisions had to be agreed to by all regions of Canada, and often involved extensive bureaucratic processes. As a result of the transition, the FNHA has gained greater autonomy over the drug benefits and a stronger voice. The FNHA has already signed an MOU and established a productive partnership with the MOH to coordinate the activities.

That being said, to date, only a few changes have been made to Plan W to reflect First Nations client needs. These changes have allowed, for example, the inclusion of some OTC medications into the formulary. The FNHA and the MOH are working to develop a three-year strategic plan to establish processes that will enable greater flexibly to allow First Nations specific benefits to be included in Plan W.

Final decisions over the changes in the formulary will be made by the MOH, which has legislative authority to determine formularies. Two challenges that the FNHA and the MOH may have to address as part of the process include the potential for resistance to providing benefits under Plan W that differ markedly from those available under other PharmaCare programs and ensuring that any additional benefits have adequate evidence-based research supporting their effectiveness.

Key informants, service providers and clients also identified a number of other beneficial impacts for clients associated with the transition to Plan W.

During interviews and surveys, key informants and survey respondents provided a number of positive impacts of the transition on clients. These impacts are summarized as follows:

- *Streamlined access to benefits due to shifting to the first payer position*. According to key informants, provider of last resort created administrative challenges for accessing benefits. Plan W is the first payer and coverage extends to all eligible First Nations people in BC regardless of their employment, family situation or other socio-economic characteristics. The approach facilitates easier access to benefits and creates less resistance at the point of service.

- *Improved access to benefits from other PharmaCare programs and provincial agencies.* For example, changes in regulations have opened up access to support under other PharmaCare programs such as Plan P for palliative care or Plan C for income assistance. There is also increased access to services under provincial agencies such as the BC Cancer Agency, BC Transplant, BC Renal Agency, BC Centre for Excellence in HIV/AIDS, BCCDC, and Provincial Retinal Disease Treatment Program.

- *Better enables First Nations clients in BC to gain access to the same care as other BC residents.* In the past, some First Nations healthcare services were delivered from BC while health and travel benefits were administered from Ottawa, which could create gaps in care. Some argued that

provincial health care tends to be more responsive to the needs and priorities of BC residents compared to care administered from Ottawa. However, provincial legislation in BC previously restricted access of First Nations to various services and benefits (e.g. agency drugs) provided by the provincial government. Changes have removed the systemic and legislative barriers and enabled First Nations health care to be more closely integrated and aligned with provincial systems. One example that was cited involved palliative care provided by the provincial government. In the past, First Nations clients had to apply to the NIHB Program and receive a rejection letter prior to being eligible for palliative care provided by PharmaCare. The delay in approvals affected many clients in the most critical and vulnerable stages of their lives. Now, palliative care can be provided as part of the coverage without requiring additional efforts and time.

- *Empowers clients to ask questions and learn about their benefits*. A few key informants note that the change encouraged First Nations clients and community representatives to ask questions to service providers about their coverage and benefits. This was a critical step in better understanding the services available to them and encouraging service providers to be more accountable.

- *May make it easier for First Nations clients, particularly those who live away from home, to access pharmacy benefits*. Not all pharmacists in BC were familiar with and knew how to navigate the NIHB system. Now, the process is much simpler as all pharmacists are familiar with the PharmaCare system.

- *Has led some clients to transition to more effective therapies*. A few key informants note that the shift required some clients who had been taking an older medication for a long time to visit their doctor who shifted the prescription to a more effective therapy. While this renewal process may have been frustrating for some clients (e.g. extra efforts associated with travelling and visiting a doctor), a few key informants note that it forced physicians to revisit the prescriptions which may have contributed to improved client well-being in the long term.

Key informants from outside of the FNHA were most likely to view the impact of the transition as negative and to view these impacts as being more immediate. While some of these impacts likely occurred only during initial phases of the transition, other negative impacts are perceived by some key informants to be on-going.

Negative impacts of the transition are summarized as follows:

Resulted in changes to therapies for many clients. The effectiveness of various therapies can vary by client, and it can take a while to find the right medication and dosage to stabilize a condition. Focus group and interview participants cited various examples where a change in therapy had resulted in poorer health outcomes including, side effects. Clients who experienced such effects had to go back to their health care provider and request special authorities to be able to continue their previous therapies. Examples mentioned by key informants most commonly related to diabetes drugs. From these accounts, it is not possible to assess how frequently that occurred (Health Directors are much more likely to hear about cases where outcomes worsened rather than there where was no impact), how quickly these negative consequences were addressed or if any are still ongoing, and whether any change in outcomes are the result of the change in therapy. During interviews, key informants mentioned that clients addressed negative consequences by obtaining special authorities to continue with previous medication,

paying out-of-pocket or seeking assistance from the FNHA, Health Directors or service providers.

Created significant confusion amongst clients regarding how to navigate the new system, most of which was gradually resolved as the transition progressed. During the surveys, 42% of Health Directors, nurses, and physicians (n=43) indicated that the ease of system navigation was worsened at the time of the transition for clients and service providers, while only 5% indicated that the system navigation was improved (35% indicated that the transition had no impact in this area). Some key informants provided examples where clients had to travel between a physician and a pharmacist several times before they were able to obtain the right prescription or had to apply for special authorities to be able to continue with therapies that they used to take prior to the transition. Several stories were recounted where clients had to make additional extended trips to see a specialist in another community to obtain a new prescription or apply for a special authority. Confusion was confounded by the fact that pharmacists and physicians did not necessarily fully understand the changes themselves, and therefore may not have been able to provide useful guidance. While the call centre was set up to help people navigate the system and help to address specific cases, it was noted by key informants that many clients were not aware of the call centre and certainly not aware of the fact that they could appeal a PharmaCare decision to the FNHA.

According to key informants and survey respondents, many of the issues that created confusion were gradually resolved as service providers and clients became more familiar with the system and the FNHA implemented measures to address problems. However, some issues (e.g. physicians prescribing medication not covered under the program, pharmacists lack of knowledge of the coverage rules, etc.) continue affecting client ability to access medication. During the survey, clients provided an average rating of 2.7 (on a scale 1 to 5, where 1 strongly disagree, 3 is neither agree or disagree, and 5 is strongly agree, n=44) to indicate that issues that they encountered with Plan W drug benefits were solved somewhat quickly. At the time of the evaluation, clients were somewhat satisfied with the Plan W overall (providing an average rating of 2.6 on a scale 1 to 5, where 1 strongly disagree, 3 is neither agree or disagree, and 5 is strongly agree, n=44). When asked what issues that still needed to be addressed with Plan W, most physicians, Health Directors and pharmacists who had an answer, indicated the main issue was to improve existing coverage and a few recommended to remove requirements for special authority for benefits that did not require prior approvals under the NIHB program.

- *Created anxiety for clients*. According to key informants, elderly clients and those with chronic conditions who have special needs that require a wide range of pharmacy and drug benefits tended to be those most affected by the transition. Change is never easy for people. These types of clients are the most vulnerable to change because it can be more difficult for them to travel, ask questions, advocate for themselves, and figure out ways to navigate the system. Trust in therapies is very important; it can be very stressful for a client to change from a therapy and dosage which is familiar and which they feel works for them to a new and unknown medication.

  Clients may have been affected emotionally (as they had to face rejection and felt let down) and may have left the counter empty-handed. Key informants note that it is difficult to estimate the extent of the impact. Due to colonization and intergenerational trauma, some First Nations may not feel empowered to advocate for their rights. Thus, when their drugs or treatments were interrupted, some did not take action to complain or ask for help. As a consequence, these clients may have suffered, and their sufferings may not have been reported.

- *Increased out-of-pocket payments.* During the surveys, 60% (n=43) of Health Directors, nurses and physicians reported that the transition increased out-of-pocket costs for clients. Only 8% reported no impact in this area. According to key informants, some clients had to pay-out-of-pocket for their benefits mainly because the benefit was denied due to technical errors in the system or due to limited knowledge of service providers (e.g. the physician prescribed medication that was not covered or pharmacists gave wrong information about the coverage). In addition, clients may have chosen to pay-out-of-pocket to cover the differences in cost for benefits that are covered by Plan W, but subject to LCA or RDP. LCA and RDP provide partial coverage for brand name products that have alternative drugs within the Plan W formularies with a similar therapeutic application. Clients may choose to continue brand name products and pay the price difference out-of-pocket.

- *Restricted access to prescriptions while travelling outside of the province*. Clients who travel outside of the BC often have to pay for their medication in advance and receive reimbursements. However, not all clients can afford prepayment.

- *Continuing access issues for some clients.* Some clients are still not registered with Plan W. Key informants also note that there are some clients whose pharmacy benefits are affected due to issues related to a status card or provincial ID. For example, according to provincial rules, if a client has not updated their identification with ICBC, the provincial government may withhold their benefits or cancel their Personal Health Number which may affect their access to pharmacy benefits. Not all clients are aware of these rules and this particularly affects those living in remote regions where it is difficult to access ICBC. Nevertheless, key informants note that only a very few clients are affected by such issues and the FNHA is actively working to address them.

Several other negative impacts mentioned by key informants. For example, kidney patients who live in remote areas may experience additional challenges in obtaining some of their drugs (under the provincial rules, not all pharmacies are allowed to dispense those drugs). To reduce costs, some clients are given a larger dosage and asked to cut their pills in half because the most appropriate dosage for them is not covered under PharmaCare (which can create challenges for elderly clients). Similarly, some clients are now provided larger volumes of insulin (e.g. six bottles instead of two) which means that they had to find a place to store it.

Key informants stress the importance of ensuring that no one (particularly the elderly and sick) loses their coverage due to technical issues (e.g. wrong Personal Health Number, expired status card) and ensuring seamless access to drugs at the pharmacy counter (e.g. adherence to Jordan's Principle, where clients are not denied a health benefit while governments fight over who should pay for the service).

On average, 41% of the clients surveyed reported being impacted by the transition while the service providers estimated that 47% of their clients were impacted.

As part of the evaluation, a survey was conducted with a sample of First Nation clients in BC and respondents were asked how the transition affected their coverage. Of the 61 survey participants who provided an answer, 41% (or 25) indicated that they experienced changes in their pharmacy coverage due the transition, 33% did not experience any changes and 26% were not sure. Of the 25 clients noting an impact, 22 reported the impact was negative, 2 indicated that it was positive, and

1 indicated it was not material. The most common negative impacts mentioned by clients include incurring out-of-pocket payment for benefits (identified by 18 clients), loss of coverage for an existing prescription (15 clients), needed to apply for special authority to be able to continue their medication (8 clients) and loss of coverage for an OTC item (5 clients). Those who experienced positive impacts noted that they have gained easier access to OTC items and their coverage was improved as a result of the transition.

As part of the surveys, Health Directors, pharmacists, physicians and nurses were asked to estimate the percent of their clients who were affected by the transition. On average, the service providers estimated that 47% of their clients were impacted. When asked to rate the extent of the impact, using a scale 1 to 5, where 1 is no impact at all, 3 is somewhat of an impact, and 5 is major impact, pharmacists provided an average rating of 4.0 (n=24) while Health Directors (n=24) and physicians (n=8) provided an average rating of 3.6. Elderly clients and clients who suffer from diabetes were identified as those most affected by the transition. Negative impacts mentioned by Health Directors, pharmacists, physicians and nurses include loss of coverage or difficulties associated with maintaining the same coverage through special authority or appeal processes (n=34), change in therapies, particularly changes from brand name to generic drugs (n=19), confusion and frustration associated with coverage and lack of information or direction that they received at the time of the transition (n=17), out-of-pocket expenditures and associated financial stress on clients (n=7) and technical glitches or issues experienced at the pharmacy counter (n=3). In terms of positive impacts, Health Directors, physicians and pharmacists mentioned that, under Plan W, it is easier for service providers to support clients because they are familiar with PharmaCare and do not have to apply to the federal program (n=5). The respondents also note that it has become easier for clients to access some OTC items and pharmacist-initiated benefits without having had to obtain a prescription (n=5). In addition, some clients have increased their interaction with service providers which have resulted in improvement to their therapies (n=3).

Various factors were identified as contributing to the negative impacts of the transition including the inability of many service providers to give useful guidance to clients regarding the changes, common misunderstandings regarding the efficacy of generic drugs, difficulties in obtaining special authorities, and the perception that PharmaCare is heavily focused on reducing costs.

These factors are summarized as follows:

- *Lack of knowledge among service providers to assist clients in navigating the system*. When asked to rate pharmacist knowledge about the Plan W benefits using a scale 1 to 5, where 1 is strongly disagree, and 5 is strongly agree, clients provided an average rating of 3.2 to indicate that pharmacists were somewhat knowledgeable. Key informants mentioned that, particularly early in the transition, pharmacists and physicians did not necessarily fully understand the changes themselves, and therefore were not in a position to provide useful guidance. Prescribers (i.e. physicians and nurse practitioners) need to have greater knowledge and access to tools and resources (e.g. coverage rules, understanding which drugs were grandfathered) to be able to assist clients at the time of the transition.

- *A lack of understanding regarding generic drugs*. There is a broad perception among some community stakeholders that generic brands are less effective than branded products and are promoted by the government primarily to save costs. Examples were cited where some community residents reported worsening health conditions as a result of changing to a generic

drug or experienced an allergic reaction which they attributed to the fillers that are used in the generic drug. It was suggested by some key informants that there is a need to increase awareness of what a generic drug is and how it can be as effective as a brand name drug. Furthermore, according to these key informants, there is a need to educate clients and service providers that switch from one name brand to another, from brands to generics, or from one generic to another generic is a standard industry practice implemented by most public sector insurance providers. The governments and insurance providers negotiate drug prices regularly by manufacturers trying to increase efficient use of resources, reduce cost and improve sustainability of the programs. Often efficiencies achieved through such negotiations are then applied to improve coverage in other areas. The exceptions (e.g. through special authorities in PharmaCare or prior approvals under NIHB) are made for some clients to ensure continuity of care and prevent adverse effects of the transition to a new medication.

- *Perceived difficulties in obtaining special authorities or appealing the rejections*. Key informants do not have data on special authorities. However, the general perception amongst key informants who commented on it was that, under Plan W, more clients require special authorities in order to gain access to the therapy recommended by the physician (more applications are submitted because the formulary is more restricted). Furthermore, because of the more restricted formulary under Plan W, more therapies are not eligible to be accessed even through a special authority. A comparative review of the benefit formularies under the NIHB and PharmaCare demonstrated that, indeed, approximately 700 of the Plan W benefits did not require prior approvals under NIHB. On the other hand, there are approximately 1,100 drugs that required a prior approval under NIHB which are an open-benefit in PharmaCare.

- *The perception that Plan W is more aggressive in pushing clients toward generic drugs and lower costs alternatives to reduce costs.* Some key informants, particularly those outside of the FNHA, perceive PharmaCare as much more cost-conscious than FNIHB and more aggressive in pushing clients towards lower cost alternatives through the RDP and LCA. However, the data indicates that both overall claim expenditures and average costs per claim increased in the year after the transition.

5.4 Impact on Service Providers

Among service providers, pharmacists were affected most by the transition. They had to deal with benefit rejections, educate clients and physicians on eligibility and coverage rules and undertake additional administrative work. While pharmacists benefited from some increases in dispensing fees, a few located in remote areas lost revenue as they no longer qualified for provincial rural incentive programs.

At the time of the transition, pharmacists had to deal with an increased number of rejections, which affected their relationships with clients as they could not meet client expectations. Some of the actions undertaken by pharmacists include calling the FNHA for a solution, passing the blame to the FNHA or PharmaCare, dispensing some medications at their own cost, or requiring the clients to pay-out-of-pocket. The situation improved gradually as pharmacists became more familiar with the new system and any technical glitches were addressed.

Other impacts reported by pharmacists include software changes (e.g. ensuring PharmaNet worked well), the introduction of the TCR forms (which requires some additional work) and the time

required to educate both physicians on how to prescribe under Plan W and clients on how to navigate the system.

The key informants also reported changes in dispensing fees. The processes used to calculate fees and issue payments under the PharmaCare are significantly different compared to those under NIHB. Changes mentioned by key informants and identified during the document review include a slight reduction in dispensing fees for regular prescription drugs for pharmacies that did not sign the 2010 Enrolment Agreement (PharmaCare pays up to $10 for prescription dispensing and $9.10 for those who did not sign the 2010 Enrolment Agreement); an increase in dispensing fees for pharmacies due to OTC items (NIHB pays $5 for OTC dispensing while PharmaCare pays up to $10 for OTCs); a loss of revenue due to a change in rules for drugs not picked up (NIHB allows a pharmacist to claim a single, non-daily, dispensing fee for prescriptions that are not picked up, PharmaCare does not), a change in rules for methadone dispensing, and the provision of witness interaction fees (e.g. as part of the provincial harm-reduction program, Plan W pays a $7.70 fee to compensate providers for witnessing clients ingesting medication). There are also changes in how dispensing fees are reimbursed (e.g. the NIHB Program provided a ten-day period to pay dispensing fees; under Plan W, fees are paid faster enabling the pharmacists to better manage their cash flow). These changes were expected to have an overall positive impact on pharmacy revenues. In particular, the transition team estimated that the program would experience at least $3.4 million increase in dispensing fees as a result of the transition. However, the transition also resulted in some pharmacies, particularly those located in rural regions, losing their eligibility for support under the provincial Rural Incentive Program (FNHA eligible benefits claimed under Plan W contribute to an increase in the claim counts of BC pharmacies; in interviews, it was noted that some pharmacies may have lost up to $40,000 in annual income as they no longer qualified for Rural Incentive Program benefits).

Physician were impacted by the change in the formulary and the requirements associated with administering special authorities. On a positive side, some doctors increased their interaction with clients, which has potential to improve client care and well-being in the long run.

Physicians, particularly those predominantly serving First Nations clients, had to learn about Plan W formularies (often by calling the pharmacist) and change their prescription practices. During the interviews, many community representatives and other key informants note that some physicians and specialists are still experiencing difficulties in prescribing medication under Plan W. During surveys, clients provided an average rating of 2.5 (on a scale 1 to 5, where 1 strongly disagree, 3 is neither agree nor disagree and 5 is strongly agree, n=32) regarding the usefulness of any assistance they received from physicians in navigating the system and accessing Plan W drug benefits. Key informants cited situations where clients were prescribed medication (or dosages) that were not covered, which resulted in claims being rejected at the pharmacy counter. During the interviews and surveys, some physicians agreed that they are still not very familiar with Plan W formularies or where to access information on coverage. Those who mentioned that they were aware that formularies can be accessed at the FNHA website still reported experiencing challenges with identifying medications that require special authority.

Physicians stated that they would have been able to assist clients much better if they were provided with information about the specific therapies that were removed from formularies as a result of the transition and alternative medications with similar therapeutic application in the new formulary that physicians can prescribe. Some physicians note that, each time there is a change in the

formulary, they would like to receive a clear communication not only about the change, but also rationale and evidence behind the change. For example, if a drug has been removed from the list because there is a better alternative in the formulary, physicians would like to see that evidence to be able to change their prescription practices and educate the client.

Finally, the new system requires physicians to play a greater role in obtaining special authorities, which increases their administrative work (particularly when special authorities grandfathered into Plan W were to expire and needed renewal) and the time they can spend with each client. In terms of positive impacts, some physicians note that their administration work reduced because they now have to deal only with one special authority system. A few key informants also state that increased client doctor interaction may contribute to client health outcomes in long-run.

5.5 Financial Impacts

The total cost of Phase 1 transition was $3.7 million, which was 61% ($1.2 million) higher than the $2.3 million originally budgeted for the project.

The FNHA spent a total $3.7 million on the transition, of which $2.1 million was allocated to cover the cost of contractors who administered the transition, $1.1 million was paid to project partners including FNIHB and MOH, and $436,277 was expended on communication and engagement activities.

The increase in cost was mostly due to a budget increase related to $0.5 million increase in the cost of MOH (Maximus) to establish Plan W within PharmaCare system, followed by an increased cost ($300,000) by Health Canada to create non-duplicate formulary to be able to administer over-the-counter medication. Other issues that raised the cost of the transition included a shift in the project launch date from July to October of 2017, increased cost of communication activities (e.g., a need to client and physician mail outs), and help with call centre and support for the operations team during the early days of the transition.

6. Lessons Learned and Opportunities for Improvement

This chapter outlines some of the key lessons learned during the transition and summarizes a wide range of recommendations mentioned by key informants, survey respondents and identified through document and file review.

6.1 Engagement and Consultations

The FNHA should ensure to undertake a meaningful engagement with First Nations representatives prior to any change in its programming and services.

Key informants note that the FNHA's mandate and guiding directives require its actions to be driven by the First Nations people and communities. Therefore, before undertaking any large-scale initiative, the FNHA should ensure that it has adequately engaged with First Nations stakeholders. Communication and engagement should be meaningful and appropriate to the community representatives. Key informants note that for the engagement activities to be meaningful, they should be started as early in the process as possible and continued until interested First Nation stakeholders (e.g. community leaders, service providers, First Nation organizations) are able to provide their input. Developing methods and strategies to reach out to and engage First Nation clients outside of the communities (e.g. in urban areas) is especially important given that a large percentage of FNHA clients who live away from home and the FNHA does not have an effective mechanism to engage with them. Communication with stakeholders should be a two-way process.

While engaging and listening to community representatives about their needs and issues, it is equally important to report back to them about the actions taken as a result. Engagement should include in-person meetings, community gatherings and discussions, visually appealing printed materials with clear messages, and through social media channels. In addition, the FNHA should involve and educate Health Directors, community leaders, and other 'community champions' to communicate their message at the community level. Developing a political storyline, conducting regular political briefings with community leaders and engaging them in the process would help with the efforts. Where possible, letters sent out to clients about the potential changes in their services should be personalized or tailored to specific target client groups. Key informants note that the FNHA should ensure to document results of the communication and engagement activities. Proper documentation would help to overcome some of the challenges associated with high staff turnover at the community level. Finally, key informants noted that it is important to review and monitor engagement activities closely and identify and incorporate lessons learned at the early stages of the communication process.

The FNHA should be open about the mistakes that it makes and undertake proper efforts to address their results.

Key informants note that the FNHA is a new organization and error or mistakes in its programming should be expected. When the FNHA is facing critical challenges, it is important to be open about them and communicate them clearly to their stakeholders and ask for advice. For example, when undertaking large scale and complex projects, the FNHA should communicate the expected

challenges, inform First Nations about the scale and complexity of the project, and request patience and understanding from stakeholders if and when errors happen. Credibility can erode when there is a disconnect between what the FNHA is communicating and what is actually happening on the ground at the community level. Key informants also praised the FNHA for demonstrating that it has realized its mistakes and taken action to make changes. According to these key informants, that would have never happened in the past with the federal government. These actions are seen to have helped improve the reputation of the FNHA.

6.2 Partnerships

Cultivating ongoing and collaborative partnerships with a range of key partners will be necessary to complete the transition process successfully.

Key informants note that efforts to build strong relationships with provincial partners will play a critical role in improving Plan W. The MOH has legislative authority to decide on PharmaCare formularies. To be able to improve Plan W and tailor its benefits to address First Nation specific needs, the FNHA will have to work closely with the provincial stakeholders. The FNHA will have to continue efforts to improve relationships with FNIHB as it is currently one of the critical players in delivering other health and travel benefits to First Nations clients in BC, and close partnership with FNIHB will ensure successful completion of the Phase 2 transition.

Key informants also note that the FNHDA and FNHC are equal partners in the health governance model in BC and should be closely involved in making major decisions that affects communities, in a manner that is consistent with the mandate established by BC First Nations for each entity that upholds the principles of separation of business and politics. Finally, key informants note that as part of the transition, the FNHA has established productive partnerships with various professional organizations (e.g. Doctors of BC, College of Physicians and Surgeons of British Columbia, BC Pharmacy Association, and College of Registered Nurses of British Columbia). The FNHA should continue to work through these bodies to educate physicians, specialists, nurses, pharmacists and other service delivery professionals on how to navigate Plan W and provide seamless services for First Nations clients.

Involving partners early in the process, providing consistent messaging and collecting ongoing feedback from partners is critical for the success of partnership efforts.

Key informants also provide a range of recommendations and best practices on how the FNHA partnership activities can be enhanced. According to key informants, it is necessary to bring partners together early in the process. It takes time to cultivate working relationships, clarify assumptions and expectations, and develop and implement joint plans of action. Furthermore, consistent and open communication and clear messaging is critical for building trusting relationships with partners. As the transition was implemented under very tight deadlines, at times, some of the communication was sent to partners last minute and appeared to be inconsistent. Communication improved as the issues were gradually resolved. Finally, key informants note that, although the FNHA implements a client satisfaction survey, it does not have an on-going mechanism to collect feedback from pharmacists, physicians or other stakeholders involved in Plan W. However, it is equally important to understand the perspectives of its partners. Therefore, there is a need to develop a mechanism to collect ongoing feedback from project partners.

6.3 Plan W and Pharmacy Benefits

The FNHA should work with partners on an on-going basis to improve Plan W.

The transition was a first and important step towards improving the quality of pharmacy benefits for BC First Nations. The FNHA should continue its efforts to learn about the needs of First Nations communities and work to tailor Plan W to better address those needs. Key informants identify a range of issues that will have to be addressed by the FNHA. These issues include improving coverage for those living at the border with other provinces, ensuring proper coverage for clients when they travel out of province, gradually absorbing the pharmacy benefits and remaining First Nations clients who are served by the NIHB Program, increasing access to emergency drugs so pharmacists can dispense these at no cost to client, revising special authority procedures so pharmacists are notified when special authorities are approved, removing barriers to Plan W eligibility (e.g. denial for services due to expired status card, being taken off Plan W list without the person's prior knowledge), removing special authority requirements for some of the most important medications that were covered under the NIHB Program and removing some of the systemic barriers that exist within Plan W. It was suggested that the FNHA should ensure that Jordan's Principle is applied at all levels of Plan W.

Contentiously educate service providers to deliver proper services to First Nation clients through Plan W.

It is critical to provide training to service delivery partners and provide them with necessary resources so they can support clients to navigate the system. There is a need to provide on-going training for service providers, to address existing knowledge gaps, train new people entering the system and inform them about changes to the system. Several key informants note that they have seen similar transitions in the past create much greater technical difficulties but have much less impact on clients. Many of Plan W clients need extra support when accessing medication. It is critical the FNHA partner with BC Pharmacy Association (and possibly with others), to provide training to service providers (particularly the pharmacists) on how to interact with clients. For example, instead of communicating that the benefit is not covered (which often results in client frustration or leaving), it is better to find a solution jointly or inform them about what actions can be taken. Furthermore, the FNHA should ensure that the PharmaCare call centre staff are trained to provide services for First Nations clients. Several key informants noted that the extent to which the call centre administered by PharmaCare (Maximus) can effectively address inquires by First Nation clients is unclear. The FNHA should work with the provincial government to ensure call centre staff are trained to serve First Nations clients in a culturally appropriate way.

Support and educate clients to navigate the system.

A few key informants note that there is a need to educate clients with respect to Plan W processes. The areas mentioned where education is most needed include the difference between generic and brand-named drugs, special authority and appeal processes and coverage and formularies. According to these key informants, Plan W system is too complex, and thus the FNHA should create, at least temporarily, client advocates who can support clients, especially elderly and those difficult health conditions, to navigate the system. Several key informants also note that the FNHA should consider renaming and rebranding Plan W as it has gained some negative association among some clients.

6.4 Transition Processes

Quick decision-making is required to undertake change management initiatives.

Key informants note that the transition faced challenges at times related to slow decision-making processes. Some of the decisions were made last minute and would have benefited from having more time for implementation. Some delays in approving project deliverables put further time pressure on the project. There is a need to find opportunities to strengthen coordination and minimize the time to complete reviews and obtain approvals for similar initiatives in the future. Organizing more focused project and partner discussions, inviting only key decision makers to the meetings, and documenting and reporting meeting results properly is critical.

Support from the most senior level, qualified and skilled staffing, open communication among team members and proper change management and planning are critical when undertaking large scale projects.

Key informants attributed the success of the transition activities to the involvement of the most senior representatives of the FNHA, qualifications and skills of the staff members involved in the project (by the FNHA and also project partners such as the MOH and Health Insurance of BC), open and ongoing communication and coordination among team members and having proper change management structures put in place.

There is a need to monitor and validate a project budget and expenditures regularly.

The FNHA established project budget based on the initial estimates made in January 2016, without the knowledge that they had not been validated by the partners. The scope of the project was changed throughout the implementation, and new estimates provided by partners in February 2017 were more than double, causing unexpected cost increase.

7. Conclusions and Recommendations

This chapter provides conclusions and recommendations resulting from the evaluation of the FNHA's Health Benefits – Pharmacy Program.

7.1. Key Findings and Conclusions

Key findings and conclusions arising from the evaluation are as follows:

1. **The decision to transition the delivery of pharmacy benefits from the NIHB Program to PharmaCare was informed by extensive consultations with First Nations representatives and internal research conducted by the FNHA.**

   Based on widespread consultations with First Nation representatives in 2011, a provision was included in the Tripartite Framework Agreement that required the transition of the delivery of pharmacy benefits from the NIHB Program to the FNHA. In 2016, based on results of the consultations and extensive research, the FNHA made the decision to transition the delivery of pharmacy benefits to PharmaCare as it had many advantages compared to other alternatives. Following the decision, the FNHA participated in Regional Caucus meetings to discuss and inform participants about the PharmaCare and benefits and potential negative impacts of the transition.

2. **The transition process was affected by tight deadlines and the scale of the transition which included all eligible registered BC First Nations, including those living in community and those living in urban areas and away from home. Despite these issues, the FNHA was able to successfully transition the delivery of pharmacy benefits to PharmaCare.**

   While FNHA management include individuals with extensive experience working with large scale transformative projects in the health system, the FNHA itself was only newly created. The organization did not have previous experience undertaking a change management initiative that include such a broad client base. Nevertheless, the FNHA created an effective governance structure and set of processes, established strong partnerships with the provincial government, contributed to regulatory changes, built the necessary infrastructure, and administered the transition of files and systems from NIHB Program to PharmaCare.

   The FNHA conducted extensive planning to understand and mitigate potential challenges and negative consequences of the transition. Some key actions taken by the FNHA include creating transitional special authorities to grandfather coverage into the new plan, establishing and expanding a call centre to address client and service provider inquiries, increasing staffing within the health benefits unit to improve services for clients, and establishing a cross-border program to ensure clients living in border regions can access benefits. The FNHA also responded quickly and effectively to various issues that arose during the transition.

3. **Plan W created a significant shift in how pharmacy benefits are provided to BC First Nations. The transition resulted in greater utilization of the pharmacy benefits.**

The shift from the NIHB Program to Plan W involved changes related to formularies, pricing, position of the first payer, dispensing fees, special authority and appeal procedures, coverage rules, and access to emergency supplies. The change has resulted in a significant increase in pharmacy benefits delivered to BC First Nations across a range of key metrics. In particular, the rate of growth in the number of claimants, claims, and expenditures in the first-year post-transition all exceeded the annual percentage increase the four years prior to the transition.

4. **The transition has generated a range of positive and negative impacts on both clients and service providers.**

   The transition enabled First Nations clients to gain access to the same care as other BC residents (e.g. accessing additional services provided by PharmaCare and provincial agencies), streamlined some processes, improved access to benefits for clients who live away from home, enabled clients to access more benefits initiated by pharmacists, and enabled some clients to shift to more effective therapies.

   The transition also generated some short-term negative impacts on clients. In particular, the differences in the formulary between the NIHB Program and Plan W resulted in many clients, including those with diabetes, experiencing a change in therapies which created confusion, increased anxiety and, for some, may have resulted in poorer health outcomes. In a survey, Health Directors, pharmacists, physicians and nurses estimated that up to one-half of their clients may have been impacted in some way by the transition. Some clients reported having to go back to their health care providers to obtain special authorities to be able to continue with their previous therapies or paying out-of-pocket, at least temporarily, for their medication. Many clients and service providers view the transition to Plan W as resulting in a more limited access to pharmacy benefits.

   The transition also impacted service providers. Pharmacists and physicians reported increased work related to administering special authorities, educating clients on the coverage rules, and processing forms. While most pharmacists benefited from some increases in dispensing fees and quicker payments, a few located in remote areas no longer qualify for provincial Rural Incentive Program payments.

5. **The transition was criticised by First Nation leaders, Health Directors and community members with regards to the FNHA handling the transition process and its engagement efforts with First Nation representatives.**

   The primary criticism was focused on the transition and was driven by two main factors. First, some key informants suggested that community representatives and Health Directors were not adequately involved in the selection of PharmaCare, design of Plan W, and planning and implementation of the transition. However, the findings of the evaluation indicate that as the evaluation was implemented under very tight deadlines, and due to evolving nature of the transition, the FNHA had very limited opportunities to incorporate changes in the design of the new program at the time of the transition. Therefore, the FNHA put an emphasis on completing the transition first with the expectation that they would then work with First Nations and PharmaCare to improve Plan W.

   Second, not enough emphasis was placed on educating and preparing clients and service providers to deal with issues that arose as a result of the transition and to mitigate potential

human impacts. While the FNHA undertook extensive communication activities to inform clients and service providers about the upcoming changes, the efforts were constrained by tight deadlines, limited in-person communication, and miscommunication between the FNHA and FNHDA. While the FNHA expected the FNHDA to take a much greater role in preparing communities for the transition, Health Directors did not feel they were adequately engaged or prepared to respond to questions received from the community.

The FNHA has undertaken much more extensive efforts to consult with First Nation stakeholders as part of the transition to other health benefits (Phase 2 of the Claims Processing System Transformation (CPST) project).

6. **The FNHA has been largely successful in addressing the negative impacts of the transition and currently is working on addressing issues associated with the transition that still affect clients.**

   At the time of this evaluation, most issues and challenges of the transition have successfully been addressed by the FNHA with the organization continuing to work on addressing any outstanding issues that are still affecting clients. Some of these issues include limited knowledge of prescribers of the Plan W formularies, client access to benefits outside of the province, training provisions for diabetes clients, and some technical issues barriers to eligibility (e.g. not all clients have been transitioned, denial for services due to expired status card, and being taken off Plan W list without the person's prior knowledge). Some clients continue paying for their benefits (or portion of the cost) out-of-pocket (or through a private insurance provider) because they choose not to transition their benefits subject to the Reference Drug Program. These challenges have further been affected by limited knowledge among clients and service providers with regards to generic drugs, and appeal procedures under Plan W.

7. **The transition has placed the FNHA in a much better position to affect improvement in pharmacy benefits going forward.**

   The transition helped the FNHA to gain a greater role in the decisions related to the delivery of pharmacy benefits to First Nation clients. The FNHA has developed a strong partnership with the provincial government that should enable it to influence Plan W formularies in the future. The major benefit of the transition is that it has allowed the FNHA, and by extension BC First Nations, to have greater influence on the FNHA's Pharmacy Program and pharmacy benefits going forward.

7.2 Recommendations

The recommendations arising from the evaluation are as follows:

1. **Building on the progress made to date, the FNHA should continue to prioritize improving Plan W.**

   - The FNHA should work closely with BC First Nations and PharmaCare to further align Plan W with the objectives established for the FNHA's Pharmacy Program, particularly the emphasis on wellness, prevention, and the empowerment of individuals to access health programs and services.

   - Monitor the impact of Plan W on clients and service providers. While the evaluation has reported on the impact of the transition at a broad level, there is a need for further research and monitoring of the impact of the transition on individual clients or groups of clients.

   - Address key issues that have been identified such as:
     - Ensuring existing coverage addresses the most important clients needs.
     - Facilitating easier access to benefits out of province.
     - Addressing technical barriers to eligibility.
     - Creating mechanisms to notify pharmacists when special authorities are approved.
     - Completing the transition of the remaining clientele into Plan W.
     - Ensuring temporary coverage extended by NIHB is transitioned into a BC-based program.

   - Ensure robust monitoring of the FNHA's Pharmacy Program including tracking of outstanding issues related to solidifying and improving the transition, and analytics, such as utilization, to ensure data is available to support targeting population health and wellness interventions that address patterns of prescribing and drug utilization.

2. **The FNHA needs to engage extensively with First Nations and service providers in planning and implementing improvements to Plan W.**

   Building on the experience gained in Phase 2 of the CPST project consultations, the FNHA should engage with First Nation clients, Health Directors and political leaders to understand their perspectives and discuss issues and opportunities to improve Plan W. An emphasis should also be placed on engaging pharmacists, physicians, and nurses.

3. **The FNHA should develop an on-going education, training, and awareness program targeted at clients and service providers.**

   The FNHA's Pharmacy Program would benefit from increasing client understanding of generic and brand name drugs, Plan W coverage, policies, special authorities, appeal procedures, and where clients can seek assistance when encountering problems with accessing benefits. Continued efforts are needed to work with service providers, particularly those who predominantly serve First Nation clients (e.g. pharmacists, physicians, nurses) to continue to

educate them on Plan W. Ongoing training for service providers should help to address existing knowledge gaps and train new people entering the system.

4. **The FNHA should incorporate the key lessons into its operating policies and plans for similar initiatives in the future.**

   The FNHA has already incorporated a number of lessons learned into its activities related to transitioning of other health benefits. The transition to Plan W has illustrated the importance of:

   - Building strong partnerships with stakeholders, engaging partners early in the process, and ensuring consistent and open communication.
   - Undertaking meaningful engagement with First Nations representatives and taking a strategic and proactive approach to engaging clients and community stakeholders.
   - Involving Health Directors, political leaders, and other champions in the communication and engagement activities.
   - Establishing a strong governance system in charge of the transition including allowing sufficient time for project planning and monitoring, budgeting, making timely decisions, ensuring support from senior management, recruiting qualified staff members, and implementing proper change management procedures.

Appendices

Appendix I: Comparison of PharmaCare and NIHB Formularies

	NIHB				PharmaCare				
AHSF Tier 1	**OTC**	**Prescription**	**Other**	**Total**	**OTC**	**Prescription**	**Other**	**Unknown**	**Total**
Antihistamine Drugs	341	51		392	77	3		16	96
Anti-Infective Agents	45	2,253		2,298	16	702		61	779
Antineoplastic Agents	4	788		792		42		3	45
Antitoxins, Immune Glob, Toxoids, Vaccines	124	165		289	6	21		8	35
Autonomic Drugs	265	723		988	48	297		23	368
Blood Derivatives	7	3		10					0
Blood Formation, Coagulation, Thrombosis	243	370		613	40	116		9	165
Cardiovascular Drugs	81	3,933		4,014	25	1461		17	1503
Central Nervous System Agents	737	5,893	11	6,641	194	2172	7	92	2465
Contraceptives (E.G. Foams, Devices)	17			17				1	1
Dental Agents	9			9	1				1
Devices	38	1		39					0
Diagnostic Agents	91	76		167	1	9		5	15
Disinfectants (For Non-Dermatologic Use)	3			3					0
Electrolytic, Caloric, and Water Balance	513	308		821	57	70		17	144
Enzymes	5	19		24	1				1
Eye, Ear, Nose and Throat (EENT) Preps.	348	715		1,063	64	260		20	344
Gastrointestinal Drugs	874	861		1,735	232	294		60	586
Gold Compounds		11		11		5			5
Heavy Metal Antagonists	1	23		24	1	13		1	15
Hormones and Synthetic Substitutes	135	1,347		1,482	91	503		27	621
Local Anesthetics (Parenteral)	96	33		129	10	215		9	234
Miscellaneous Therapeutic Agents	210	619		829					0
Oxytocics		15		15		1		6	7
Pharmaceutical Aids	118	4		122	8	3		2	13
Respiratory Tract Agents	400	358	1	759	39	91		8	138
Skin and Mucous Membrane Agents	1,394	792		2,186	176	383		29	588
Smooth Muscle Relaxants	8	214		222	3	87		14	104
Unknown	6,576	3,067	73	9,716	244	236	10	246	736
Vitamins	1,087	87		1,174	62	32		11	105
Grand Total	**13,770**	**22,729**	**55**	**36,584**	**1,396**	**7,016**	**17**	**685**	**9,114**

Source: Master Formulary List (August 2018)

Appendix II: Changes in Claims Value for Leading Products

Comparison of the Value of Claims For Leading DIN/PINs in the Years Pre and Post Transition

Leading Products (Over $250,000 in claims)	Pre-Amount	Post-Amount	Change
Harvoni	$ 3,479,323	$ 1,732,249	-$1,747,074
Epclusa	$ 3,036,669	$ 8,741,378	$5,704,709
Humira	$ 2,178,011	$ 2,949,434	$771,423
Enbrel	$ 1,916,798	$ 1,995,691	$78,893
Methadone (Methadose) 10mg/Ml - Direct Interaction	$ 1,443,891	$ 1,986,762	$542,871
Remicade	$ 953,010	$ 1,375,376	$422,366
Rituxan	$ 889,760	$ 1,050,396	$160,636
Tylenol With Codeine No. 3 - Tab	$ 850,187	$ 812,426	-$37,761
Flovent HFA	$ 753,513	$ 850,587	$97,074
Lantus	$ 719,760	$ 970,807	$251,047
Sovaldi	$ 500,750	$ -	-500,750
Invega Sustenna	$ 490,499	$ 763,672	$273,173
Mirena	$ 474,238	$ 556,088	$81,850
Cust Intrnl Ftwear Devices,Pr	$ 448,850	$ 500,140	$51,290
Digital, Basic, R	$ 419,169	$ 406,958	-$12,211
Suboxone	$ 409,617	$ 468,561	$58,944
Digital, Basic, L	$ 409,179	$ 413,283	$4,104
Lantus	$ 395,106	$ 503,037	$107,931
Assess/Fit/Dispensing Fee,R	$ 387,676	$ 378,188	-$9,488
Orencia	$ 375,537	$ 435,197	$59,660
Assess/Fit/Dispensing Fee,L	$ 375,072	$ 385,656	$10,584
Cymbalta	$ 360,999	$ 92,825	-$268,174
Ratio-Lenoltec No 3	$ 345,264	$ 385,499	$40,235
Zepatier	$ 327,132	$ 1,599,038	$1,271,906
Needles/Syringes-Insulin Use	$ 321,468	$ 433,913	$112,445
Invega Sustenna	$ 316,587	$ 491,625	$175,038
One Touch Ultra Blood Glucose Test Strips	$ 312,868	$ 276,115	-$36,753
Onetouch Verio Blood Glucose Test Strips	$ 307,049	$ 367,763	$60,714
Advair 250	$ 303,075	$ 347,502	$44,427
Holkira Pak	$ 302,725	$ -	-
Volibris	$ 301,412	$ 292,904	-$8,508
Epipen	$ 291,247	$ 269,006	-$22,241
Wheelchair, Manual, Purch	$ 272,272	$ 325,199	$52,927
Simponi	$ 265,444	$ 304,526	$39,082
Pms-Cetirizine	$ 255,690	$ 402,824	$147,134
Simponi	$ 252,878	$ 343,735	$90,857
Symbicort 200 Turbuhaler	$ 232,441	$ 293,077	$60,636
Abilify Maintena	$ 204,774	$ 324,941	$120,167
Trajenta	$ 198,118	$ 386,559	$188,441
Xarelto	$ 180,704	$ 272,029	$91,325
Xeljanz	$ 160,455	$ 296,978	$136,523
Jamp Acetaminophen 500	$ 97,083	$ 292,150	$195,067
Kadian 100 Mg Capsule	$ 204	$ 250,475	$250,271

Source: FNHA Year 1 Pre Post Comparison Data

Appendix III: Changes in Claims for Anti-Diabetes Products

Comparison of the Value of Claims For All Anti-Diabetes DIN/PINs in the Years Pre and Post Transition

AHFS Tier 3	Name	Pre-Transition	Post	Change	Program
ALPHA-GLUCOSIDASE INHIBITORS	GLUCOBAY	$1,640	$924	-$716	NIHB
	GLUCOBAY	$2,573	$1,805	-$768	NIHB
BIGUANIDES	ACT METFORMIN	$1,688	$1,055	-$632	BOTH
	ACT METFORMIN	$15,047	$16,145	$1,098	BOTH
	APO-METFORMIN - TAB 500MG	$39,387	$31,759	-$7,629	BOTH
	APO-METFORMIN 850 MG TABLETS	$648	$1,392	$745	BOTH
	AURO-METFORMIN	$178	$1,347	$1,169	BOTH
	AURO-METFORMIN	$4,199	$44,825	$40,626	BOTH
	ECL-METFORMIN	$4,416	$-	-$4,416	NIHB
	ECL-METFORMIN	$321	$-	-$321	NIHB
	GLUCOPHAGE	$438	$304	-$135	BOTH
	GLYCON	$157	$32	-$126	BOTH
	GLYCON 850MG	$8	$-	-$8	BOTH
	JAMP-METFORMIN	$425	$6,096	$5,670	BOTH
	MAR-METFORMIN	$55	$-	-$55	BOTH
	MAR-METFORMIN	$1,362	$2,263	$901	BOTH
	METFORMIN	$1,259	$7,425	$6,166	BOTH
	METFORMIN	$30,416	$141,577	$111,161	BOTH
	METFORMIN FC	$5,925	$5,688	-$237	BOTH
	METFORMIN FC	$99,300	$142,947	$43,647	BOTH
	MYLAN-METFORMIN	$175	$15	-$160	BOTH
	MYLAN-METFORMIN	$1,196	$1,660	$464	BOTH
	PMS-METFORMIN	$1,282	$1,748	$466	BOTH
	PMS-METFORMIN - TAB 500MG	$36,750	$22,501	-$14,248	BOTH
	RAN-METFORMIN	$3,871	$2,548	-$1,322	BOTH
	RAN-METFORMIN	$26,722	$17,164	-$9,558	BOTH
	RATIO-METFORMIN	$1,234	$306	-$928	BOTH
	RATIO-METFORMIN	$25,556	$20,650	-$4,906	BOTH
	SANDOZ METFORMIN FC	$10,402	$6,891	-$3,511	BOTH
	SANDOZ METFORMIN FC	$187,978	$115,409	-$72,569	BOTH
	SEPTA-METFORMIN	$150	$79	-$72	BOTH
	TEVA-METFORMIN	$16	$-	-$16	NIHB
DIPEPTIDYL PEPTIDASE-4(DPP-4) INHIBITORS	JANUMET	$9,261	$2,561	-$6,701	NIHB
	JANUMET	$18,712	$4,297	-$14,414	NIHB
	JANUMET	$232,221	$67,159	-$165,062	NIHB
	JANUMET XR	$170	$-	-$170	NIHB
	JANUMET XR	$683	$766	$84	NIHB
	JANUMET XR	$61,302	$19,562	-$41,739	NIHB
	JANUVIA	$3,209	$762	-$2,447	NIHB
	JANUVIA	$10,146	$2,878	-$7,268	NIHB
	JANUVIA	236,278	$71,322	-$164,956	NIHB
	JENTADUETO	$2,435	$6,582	$4,147	BOTH
	JENTADUETO	$4,522	$27,710	$23,188	BOTH
	JENTADUETO	$34,525	$174,173	$139,648	BOTH
	KOMBOGLYZE	$668	$1,229	$561	BOTH
	KOMBOGLYZE	$1,108	$3,178	$2,071	BOTH
	KOMBOGLYZE	$16,540	$36,767	$20,227	BOTH

AHFS Tier 3	Name	Pre-Transition	Post	Change	Program
	ONGLYZA	$5,477	$11,017	$5,539	BOTH
	ONGLYZA	$31,948	$55,157	$23,210	BOTH
	TRAJENTA	$198,118	$386,559	$188,441	BOTH
INCRETIN MIMETICS	TRULICITY	$223	$-	-$223	NIHB
	VICTOZA	$11,807	$7,387	-$4,420	NIHB
INSULINS	APIDRA	$1,403	$777	-$626	BOTH
	APIDRA	$8,791	$5,911	-$2,880	BOTH
	APIDRA	$19,803	$11,614	-$8,189	BOTH
	HUMALOG	$9,625	$9,785	$160	BOTH
	HUMALOG (CARTRIDGE)	129,241	$148,852	$19,612	BOTH
	HUMALOG (KWIKPEN)	$37,478	$39,519	$2,041	BOTH
	HUMALOG 200 UNITS/ML KWIKPEN	$2,463	$2,678	$215	NIHB
	HUMALOG MIX 25 (CARTRIDGE)	$25,327	$28,623	$3,296	BOTH
	HUMALOG MIX 25 (KWIKPEN)	$13,359	$14,158	$798	BOTH
	HUMALOG MIX 50 (CARTRIDGE)	$2,931	$4,858	$1,927	BOTH
	HUMALOG MIX 50 (KWIKPEN)	$1,970	$763	-$1,207	BOTH
	HUMULIN 30/70 (INSULIN HUMAN BIOSYNTH INJ)	$2,112	$1,755	-$357	BOTH
	HUMULIN 30/70 CARTRIDGE	$57,914	$67,321	$9,406	BOTH
	HUMULIN N	$8,562	$8,467	-$95	BOTH
	HUMULIN N (CARTRIDGE)	$85,794	$98,783	$12,989	BOTH
	HUMULIN N (KWIKPEN)	$17,014	$26,827	$9,814	BOTH
	HUMULIN R	$7,701	$6,320	-$1,381	BOTH
	HUMULIN R CARTRIDGE	$26,996	$34,936	$7,941	BOTH
	LANTUS	$12,707	$12,410	-$297	BOTH
	LANTUS	$395,106	$503,037	$107,931	BOTH
	LANTUS	$719,760	$970,807	$251,047	BOTH
	LEVEMIR FLEXTOUCH	$38,529	$57,168	$18,639	BOTH
	LEVEMIR PENFILL	$96,470	$102,850	$6,380	BOTH
	NOVOLIN GE 30/70	$2,577	$2,830	$253	BOTH
	NOVOLIN GE 30/70 PENFILL	$68,792	$69,397	$606	BOTH
	NOVOLIN GE 40/60 PENFILL	$475	$547	$72	BOTH
	NOVOLIN GE 50/50 PENFILL	$2,778	$2,133	-$645	BOTH
	NOVOLIN GE NPH	$1,468	$803	-$664	BOTH
	NOVOLIN GE NPH PENFILL	$120,395	$138,006	$17,611	BOTH
	NOVOLIN GE TORONTO PENFILL	$18,847	$18,155	-$692	BOTH
	NOVOMIX 30	$2,243	$4,268	$2,025	BOTH
	NOVORAPID	$18,087	$20,114	$2,027	BOTH
	NOVORAPID	$43,472	$47,712	$4,239	BOTH
	NOVORAPID	$138,888	$161,955	$23,067	BOTH
	TOUJEO SOLOSTAR	$29,561	$41,773	$12,212	NIHB
MEGLITINIDES	ACT REPAGLINIDE	$795	$265	-$530	NIHB
	ACT REPAGLINIDE	$784	$367	-$417	NIHB
	ACT REPAGLINIDE	$3,007	$2,280	-$727	NIHB
	GLUCONORM 0.5MG	$601	$508	-$93	NIHB
	GLUCONORM 1.0MG	$455	$505	$50	NIHB
	GLUCONORM 2.0MG	$227	$-	-$227	NIHB
	SANDOZ REPAGLINIDE	$1,016	$94	-$922	NIHB
	SANDOZ REPAGLINIDE	$162	$513	$351	NIHB
SODIUM-GLUC COTRANSPORT 2 (SGLT2) INHIB	FORXIGA	$11,641	$14,366	$2,725	NIHB
	FORXIGA	$18,128	$21,352	$3,224	NIHB
	INVOKANA	$119,233	$95,576	-$23,657	NIHB

AHFS Tier 3	Name	Pre-Transition	Post	Change	Program
	INVOKANA	$206,764	$175,419	-$31,345	NIHB
	JARDIANCE	$58,807	$63,475	$4,668	NIHB
	JARDIANCE	$68,020	$98,400	$30,380	NIHB
	XIGDUO	$265	$1,690	$1,425	NIHB
SULFONYLUREAS	APO GLYBURIDE TAB 2.5MG	$5,824	$4,228	-$1,597	BOTH
	APO GLYBURIDE TAB 5MG	$23,812	$20,934	-$2,879	BOTH
	APO-GLICLAZIDE	$11,637	$16,692	$5,056	BOTH
	APO-GLICLAZIDE MR	$26,938	$18,476	-$8,462	BOTH
	APO-GLICLAZIDE MR	$30,185	$22,700	-$7,485	BOTH
	DIAMICRON	$523	$516	-$7	BOTH
	DIAMICRON MR	$8,259	$1,627	-$6,632	BOTH
	DIAMICRON MR	$3,519	$3,030	-$490	BOTH
	GLICLAZIDE	$10,368	$11,600	$1,233	BOTH
	GLYBURIDE	$3,839	$4,988	$1,150	BOTH
	GLYBURIDE	$14,804	$16,685	$1,881	BOTH
	MINT-GLICLAZIDE MR	$5,037	$19,082	$14,045	BOTH
	MINT-GLICLAZIDE MR	$73,093	$96,663	$23,570	BOTH
	MYLAN-GLICLAZIDE	$3,150	$498	-$2,652	NIHB
	MYLAN-GLICLAZIDE MR	$1,281	$2,498	$1,218	BOTH
	PMS-GLYBURIDE	$2,223	$-	-$2,223	NIHB
	SANDOZ GLYBURIDE	$729	$-	-$729	BOTH
	TEVA-GLICLAZIDE	$15,409	$13,674	-$1,735	BOTH
	TEVA-GLYBURIDE	$2,251	$7,706	$5,456	BOTH
	TEVA-GLYBURIDE	$7,894	$27,915	$20,021	BOTH
	TOLBUTAMIDE	$409	$207	-$201	BOTH
THIAZOLIDINEDIONES	ACCEL PIOGLITAZONE	$77	$298	$221	BOTH
	ACH-PIOGLITAZONE	$514	$-	-$514	BOTH
	ACH-PIOGLITAZONE	$951	$224	-$727	BOTH
	APO-PIOGLITAZONE	$2,735	$1,495	-$1,240	BOTH
	APO-PIOGLITAZONE	$2,005	$2,232	$227	BOTH
	APO-PIOGLITAZONE	$1,341	$2,667	$1,325	BOTH
	AVANDIA	$630	$1,268	$638	NIHB
	AVANDIA	$1,812	$1,872	$60	NIHB
	MINT-PIOGLITAZONE	$822	$992	$170	BOTH
	MINT-PIOGLITAZONE	$1,492	$1,908	$416	BOTH
	MYLAN-PIOGLITAZONE	$218	$994	$776	BOTH
	MYLAN-PIOGLITAZONE	$1,139	$1,386	$247	BOTH
	MYLAN-PIOGLITAZONE	$3,118	$3,138	$20	BOTH
	PMS-PIOGLITAZONE	$120	$-	-$120	BOTH
	SANDOZ PIOGLITAZONE	$105	$-	-$105	BOTH
	SANDOZ PIOGLITAZONE	$110	$166	$55	BOTH
	SANDOZ PIOGLITAZONE	$386	$208	-$178	BOTH
	TEVA-PIOGLITAZONE	$166	$221	$55	BOTH
	VAN-PIOGLITAZONE	$105	$-	-$105	BOTH

Source: FNHA Year 1 Pre Post Comparison Data

Appendix IV: Glossary of Acronyms

AHFS	American Society of Health-System Pharmacists
BC	British Columbia
CPST	Claims Processing System Transformation
DIN	Drug Identification Number
FNHA	First Nations Health Authority
FNHADW	FNHA Data Warehouse
FNHC	First Nations Health Council
FNHDA	First Nations Health Directors Association
FNIHB	First Nations and Inuit Health Branch
NIHB	Non-Insured Health Benefits
LCA	Low Cost Alternative
MOH	Ministry of Health
MOU	Memorandum of Understanding
OTC	Over-the-counter
PIN	Product Identification Number
RDP	Reference Drug Program
TCR	Transitional Coverage Request