

20 District Health Boards

PHARMAC
Pharmaceutical Management Agency

**PHARMAC & 20 DHBs
Consultation Proposals**

**Pharmaceutical Schedule Rules
Community Pharmacy Services**

February 2011

Table of Contents

Cover Letter	3
Application of the Official Information Act	4
Introduction	6
Overview of the Consultation Proposals	9
PHARMAC Consultation Proposals	12
Introduction	12
Proposal One: Close Control Rule changes	13
Proposal Two: A patient-centred system for people with Long Term Conditions with objective, auditable Access Criteria and electronic Special Authority mechanism	15
Proposal Three: Review of Schedule listings to ensure there is consistency of dispensing frequency across chemical groups where possible; and to review the listing rule that requires all new medications to be listed with monthly dispensing for an initial period of twelve months.	21
20 DHB Consultation Proposals	22
Proposal One: Patient-Centred Service for People with Long Term Conditions	22
Service Description	22
Funding the Service	23
Proposal Two: Provision of Pharmacy Services to People in Age Related Residential Care	25
Service Outline	26
Pharmacy Agreement Considerations	28
Funding the Service	29
Proposal Three: Provision of Pharmacy Services to People with Disabilities in Community Residential Support Services.....	30
Process	30
Proposal	31
Service Outline	31
Pharmacy Agreement Considerations	33
Funding the Service	34
Appendix 1: Proposed Close Control wording	36

Cover Letter

Dear Stakeholders

PHARMAC and the 20 DHBs received thoughtful and wide-ranging responses to the discussion documents they circulated in November 2010:

Review of the Pharmaceutical Schedule rules related to:

- Close Control
- Distribution of Special Foods to Patients
- Distribution of Higher Cost Products to Patients.

Pharmacy Services to People in Age Related Residential Care

Pharmacy Services to People in Community Residences

The feedback has been discussed with the Pharmacy Services Steering Group, whom we have been working intensively with for more than a year, within our own organisations and with each other, and have developed the consultation proposals after reflecting on the advice received.

PHARMAC and the 20 DHBs are releasing the consultation proposals jointly so stakeholders can clearly see how the proposals relate to each other. The proposed changes to the Pharmaceutical Schedule's rules have a patient, rather than a medicine, focus. They recognise the high needs and vulnerability of three particular groups of patients and support a multi-disciplinary clinical team approach to patient care as do the 20 DHBs' proposals which clarify the service expectations for these patients. Inmates in penal institutions will be eligible for monthly dispensings, and DHBs and the Department of Corrections will continue their respective funding contributions.

The proposals might be seen as aspirational. We were told that many pharmacies are providing these services now as they are within the scope of the current service specifications. We received examples of multi-disciplinary teams who work this way for the benefit of their patients but do not feel recognised for their patient focus in a system where funding is tied to each prescription item rather than to services. We aspire to embed these services as the New Zealand way of working, with funding determined not by the number of medicines a patient is on, but by the services that will help improve adherence to their treatment regime and maintain or improve their health. The aspirational nature of the proposals may be more about getting everyone working to the same service specification, and sharing common platforms of care across the continuum of care settings.

We emphasise that no decisions have been made about the consultation proposals. We want to hear the views of all stakeholders. We will continue to engage with the Pharmacy Services Steering Group, and with each other, throughout the process. We understand that the community pharmacy

sector wants certainty so they can manage their businesses during any change process. We know patients will want clarity about what they can access when they go to their community pharmacy. Prescribers (general practitioners, nurse practitioners, hospital doctors) will also want to understand what any changes would mean for them in their professional dealings with community pharmacy; so will age related residential care providers and providers with community residences. We reiterate that we are working within the current community pharmacy expenditure, plus an allowance for growth within DHBs' funding path.

You might be interested in all the proposals or you might have a specific interest in one or more of them. We encourage you to read through the whole document so you can see how the proposals fit together and what the questions are asking you to consider before you respond. We have attached a separate response sheet for you to use. We will also be looking to meet with key stakeholder groups.

It is very important to us that we receive feedback from stakeholders. We anticipate the feedback will be robust and challenging. It will be welcome and valuable as any changes to the current system must be feasible, able to be implemented in a straightforward way, in one or more steps. If you wish to present alternative proposals that you think would be better, we invite you to do so.

Please provide your feedback to all the proposals by 5pm Friday 18th March 2011. Feedback should be sent to:

Email: pharmacycommunity@dhbz.org.nz

Fax: 04 460 4995

Post: PO Box 10-254, Wellington 6011

Rachel Mackay and Janice Donaldson are the key contact people. Their contact details are:

Rachel Mackay, 04 9167508, 021 911 865, Rachel.mackay@pharmac.govt.nz

Janice Donaldson, 0274 726 632, Janice.donaldson@dhbz.org.nz.

After receiving consultation responses, PHARMAC and the 20 DHBs will consider the feedback in April 2011. Decisions made may result in changes to the Community Pharmacy Agreement that is to come into effect on 1 September 2011. There will be a separate process to consult on changes to the Agreement.

Application of the Official Information Act

Your submission and all correspondence you have with PHARMAC and the 20 DHBs may be the subject of requests under the Official Information Act 1982 (OIA). If there is any part of your submission or correspondence that you consider could properly be withheld under the OIA, please include comment to this effect along with reasons why you want the information withheld. Information

about the reasons for withholding information under the OIA can be found at the Ombudsmen's website: www.ombudsmen.govt.nz.

If you are making your contribution as an individual as opposed to an organisation, we will omit your personal details from the submission if you include the following statement at the front of your submission and sign it:

'I do not give my permission for my personal details to be released to persons requesting my submission under the Official Information Act 1982.'

Thank you for taking the time to review this document and provide your feedback.

Yours sincerely



Matthew Brougham	Dr Sharon Kletchko	Kim Tito
Chief Executive	Co-Lead GM Planning & Funding	Co-Lead GM Planning & Funding
PHARMAC	Nelson-Marlborough DHB	Northland DHB

Introduction

For more than a year, the 20 DHBs and PHARMAC have been working very closely with the pharmacy sector, primary care and the Ministry of Health on ways to evolve pharmacy services for people who require support to manage their medicines, adhere to their treatment regime and improve their health outcomes.

The 20 DHB contractual arrangements with over 900 community pharmacies are due for renewal on 1 September 2011, and this work will inform the contracting process.

Medicines are paid for through the Community Pharmaceutical Budget which PHARMAC manages on behalf of the 20 DHBs. PHARMAC also manages the Pharmaceutical Schedule whose rules, e.g. Close Control currently determines a significant amount of pharmacy income.

The consultation proposals in this document follow on from the 20 DHB and PHARMAC discussion documents processes undertaken in November 2010. The feedback themes to those documents have informed these proposals. A summary of the 20 DHB discussion documents is available at www.dhbnz.org.nz. The PHARMAC summary document is available at www.pharmac.govt.nz.

The intensive work programme with the key stakeholders has been motivated by the following perceived weaknesses in the current system:

- A focus on medicines rather than on the patient and their needs
- Inconsistent application of a multi-disciplinary team approach
- Variable recognition of community pharmacy's clinical skills and expertise
- Uncertainty about whether patients with the highest health needs are receiving the level of support that community pharmacy could provide to assist them adhere to, and benefit, from their treatment regime i.e. right services, right place, right time
- The fee for service (i.e. fee per script item) funding model incentivises a focus on the medicines supply chain function rather than a patient service focus
- Community Pharmacy Agreement expenditure has been growing at 7 - 8% each year (compared with DHBs' funding path which has been growing at 2.5 – 3% each year. DHBs expect expenditure on the Community Pharmacy Agreements¹ to cost about \$380 million in 2010/11. Some reasons for this growth can be explained, such as increases in the population, ageing population, new medicines, prescription numbers, numbers of medicines on a script , but these don't account for all the growth
- Growth in the use of Close Control, particularly weekly Close Control, has been exceeding expectations in recent years, with growth occurring unevenly across DHBs. In 2009/10 the 20 DHBs spent about \$78 million² for prescriptions dispensed as Close Control. The growth is

¹ Community Pharmacy Agreement: payments are made for dispensing fees and mark-ups

² This is the additional cost of dispensing prescriptions more frequently than the default dispensing for each medicine, either monthly or three monthly (all-at-once). It includes monthly close control for age-related residential care. It excludes formulations other than tablets and capsules.

not totally explainable by clinical factors pertinent to a district or population cohort. Feedback from the discussion document process indicated that some Close Control is funding patient monitoring and compliance packaging for patients' medicines. Medical practitioners reported that, in general, they don't understand the Close Control rules well and take advice from pharmacists. DHBs query whether Close Control is the best mechanism for improving patients' use of medicines.

While the weaknesses are acknowledged by all stakeholders, and there is mutual willingness to work on the issues, there isn't an agreed set of solutions. The 20 DHBs and PHARMAC have listened carefully to the wide-ranging information and feedback received over the past year. They have considered policy settings and directions and national and international literature about quality and safety, compliance and adherence issues for patients, the role of pharmacists and the contribution of the multi-disciplinary team to improving patients' health.

The 20 DHBs and PHARMAC are now consulting on proposals that intend to more clearly describe a patient-centred service focus to pharmacy service and medicines delivery. In developing these proposals we have sought to focus on positive benefits for the identified patient groups and for the clinicians involved with them. For the most part, the proposals are intended to reflect patient-centred services that are currently offered by a good number of pharmacies and are within a community pharmacist's current scope of practice. Possible mechanisms to achieve these desired directions have been included for feedback.

The PHARMAC and 20 DHB proposals form an inter-related package. For ease of reference and understanding they are set out in one document. If, for example, you are primarily interested in pharmacy services to people in Community Residences or Age Related Residential Care, as well as reading the DHB service proposals it is important that you read PHARMAC's proposals about monthly dispensings to residents in these services along with the Close Control rule proposals. Similarly, if you are interested in people who have multiple long term conditions (for example: combinations of diabetes, heart disease, chronic lung disease, cancers, neurosensory disorders, chronic pain) and are on multiple medications (which often interact negatively as well as positively) your attention is drawn to the Close Control rule proposals and the proposals for people with Long Term Conditions.

Implementing these proposals, should that occur following consultation, would involve a redistribution of funding towards patients with the highest needs and the capacity to achieve health outcome benefits from regular, consistent clinical input. The questions in the document focus mostly on the service proposals. It is important to enable wide feedback on the feasibility and desirability of the service proposals. It is also important that respondents have the opportunity to present alternative proposals for consideration that may better address the weaknesses in the current system.

The consultation process will run its course, feedback will be considered and decisions finalised before implementation, pricing and contracting mechanism issues are defined too specifically. However, whilst the consultation process is occurring, we will be continuing to work with the Pharmacy Services Steering Group and others on these matters, including the use of technology, funding, contracting and payments mechanisms, linkage with initiatives such as *Better Sooner More Convenient Services*, *Whanau Ora* and *Trends in Service Design and New Models of Care* and whether there should be demonstration sites, staggered evolution or one national approach. Until the service decisions have been made, these other matters cannot be finalised. However, that work will add to the information base to support and better inform the next stages.

The 20 DHBs and PHARMAC acknowledge the importance of evolving and transitioning the services and funding in a way that gives patients, pharmacy and other providers certainty and is clear, understandable and accountable. PHARMAC and the 20 DHBs are interested in optimal health outcomes and optimal financial stewardship.

The 20 DHBs reiterate that the funding envelope within which community pharmacy services will evolve is the current Community Pharmacy Agreement expenditure, plus an allowance for growth within the 20 DHBs' funding path in 2011/12 and future years.

Overview of the Consultation Proposals

The 20 DHBs and PHARMAC have set out their respective consultation proposals in one document so readers can see how they work together. The key focus is on a patient-centred system.

PHARMAC is proposing to change some Pharmaceutical Schedule Rules, such as the current Close Control rules, and to introduce a Patient-centred system of care and support to provide access to pharmacy services for people with Long Term Conditions. Criteria for the Patient-centred system need to be developed and agreed. Respondents are asked to comment on the suggested criteria and offer other auditable criteria. The access mechanism proposed is a Special Authority because it is an existing, well known and well used mechanism. It is not intended to add to either the prescriber's or pharmacy's workload. Instead, we are seeking to reduce compliance costs overall and change the interactions between prescribers and pharmacy, while at the same time ensuring that appropriate targeting and auditing can occur. In our view this is best achieved through a Special Authority Mechanism, but we welcome other suggestions.

It is proposed that people living in Age Related Residential Care, people with Mental and Intellectual Disabilities living in community residences and people in penal institutions will be able to receive monthly dispensings. Prescriptions would include the patient's NHI number and the name of the residence or institution but there would be no requirement to annotate medicines as Close Control. Again the intention is to reduce compliance and Close Control interactions between the prescriber and community pharmacy.

The 20 DHBs are proposing to set clearer pharmacy service expectations for three groups of vulnerable patients who have high needs, are prescribed the most medicines and would meet objective access criteria for additional community pharmacy support. These groups would access services either via PHARMAC's proposed Patient-centred system or the amended Close Control rules.

The three patient groups are:

1. People with Long Term Conditions, multiple co-morbidities, multiple medications, diminished self-management capacity and capability, and compromised health and life expectations if adherence and compliance with their treatment regime does not occur
2. People in Age Related Residential Care (ARRC)
3. People with Mental and Intellectual Disabilities, living in Community Residences funded by DHBs or the Ministry of Health.

PHARMAC Proposals		20 DHBs Proposals
Change Close Control Rules	Limit use of Close Control to specified drugs	People must either meet criteria for Close Control, or otherwise be eligible to receive services through one of the three DHB service proposals below [Close Control rules will not apply to these services]
	Review rule that limits listing new chemicals stat for 12 months	
	Review inconsistencies in dispensing periods for similar medications	
Services for Patients in Residences/ Institutions	Allow monthly dispensing for people in ARRC, Community Residences, Penal Institutions	Clarify service expectations for People in ARRC, Community Residences, Penal Institutions Seek feedback on funding mechanisms and contracting arrangements
Services for Patients with Long Term Conditions	Create a Patient Centred system: <ul style="list-style-type: none"> ▪ Mechanism [Special Authority suggested] ▪ Access criteria [to be agreed by DHBs and PHARMAC] 	Propose service expectations for people with Long Term Conditions Seek feedback on funding mechanisms and contracting arrangements

The 20 DHBs and PHARMAC also advise their intentions to issue a joint Request for Information regarding the distribution of Special Foods and High Cost Medicines in the very near future.

The consultation proposals fit with the Pharmacy Services Steering Group's³ established principles:

- a. Patient self management and safety combine with involvement and support of their multidisciplinary team [pharmacy, primary and secondary care, community and residential providers as appropriate] to improve the health of vulnerable patients
- b. Explicit valuing of pharmacists' clinical skills and contribution to primary care delivery
- c. Prioritised, affordable development of community pharmacy services within DHB funding parameters, with risks managed
- d. Open transparent processes, with clear decision making processes
- e. Stakeholder involvement.

They also support national strategic policy directions e.g. *Better Sooner More Convenient Services; Disability [Live an Everyday Life] and Mental Health [Opportunities to Live an Ordinary Life]*. It is also intended that the supply, distribution, service and funding incentives are aligned to the desired service objectives of:

³ Pharmacy Services Steering Group: DHB regional representatives; PHARMAC; Ministry of Health Primary Care and Sector Services; Pharmacy Agents; Primary Care Prescriber

- a. improving the patient journey
- b. supporting patient self-management where possible
- c. involving the multidisciplinary team
- d. using prescribed medicines as efficiently and effectively as possible
- e. reducing administrative requirements where possible

There is no intention to shift costs between pharmacy and other services funded by DHBs or Ministry of Health e.g. the ARRC Agreement.

This is an aspirational set of proposals. Phasing the changes, to be determined after consultation feedback has been received, will reflect the ability of patients and the sectors - primary and secondary care, pharmacy, age related and community residences - to embed the clinical and multidisciplinary team service expectations.

The 20 DHBs and PHARMAC want to receive comments on the optimal change timeframe bearing in mind that the funding released from the change to the Close Control rules will transfer to the service models, so alignment of the changes is highly desirable.

PHARMAC Consultation Proposals

Introduction

Responses from the November 2010 discussion document process indicate that while Close Control is moderately successful in providing better monitoring and review of adherence, there are some concerns around the appropriate use of the system. A strong theme which ran through much of the feedback was that the focus in close control dispensing needs to be on the individual patient, not the medicine.

PHARMAC proposes to make some significant changes to Close Control to enable the development of a more targeted, patient-centred system which would support adherence and compliance services for the those high needs patients who are within the top 15% of the population receiving medications in terms of number of medicines prescribed, dispensings accessed, cost and pharmacy workload.

Members of the patient's multi-disciplinary team would be involved in the patient-centred service approach to improve adherence to the treatment regime and thus gain health benefits and value from health funding. There would be more flexibility for synchronisation; medication screening and reviews. Compliance packaging could become a recognised service for appropriate patients. Funds released by changes to the Close Control rules could transfer to the services DHBs are proposing for high need patient groups.

The proposals are congruent with the strategic and operational directions related to *Better Sooner More Convenient Care*, the National Health IT Plan and Health Workforce NZ, and are fully supported by the 20 DHBs.

The three key aspects of the proposals are:

1. Change the current Close Control rule to significantly limit its use in its current form.
2. Specify in the Pharmaceutical Schedule that people in Age Related Residential Care, Intellectual Disability and Mental Health Community Residences and Penal Institutions can receive monthly dispensing.
3. In conjunction with DHBs, develop a patient-centred service focusing on compliance and adherence for people with high needs living in the community. Auditable access criteria

would apply and an electronic patient-centred Special Authority could be used as the mechanism to implement the service⁴.

In addition, PHARMAC also proposes to undertake a review of Schedule listings to ensure there is consistency of dispensing frequency across groups where possible; and to review the listing rule that requires all new medications to be listed with monthly dispensing for an initial period of twelve months.

Proposal One: Close Control Rule changes

PHARMAC is proposing changes to the Close Control rule, which is set out in the Pharmaceutical Schedule, to more clearly identify which patient groups are eligible for Close Control. The proposal is for the patients to whom the rule currently applies to effectively be split into three groups:

1. Monthly dispensing for patients in specified residences and institutions. This would provide better management of the delivery of medicines in institutions for patients in aged residential care, community residences or penal institutions. Proposed changes include adding penal institutions and treating all items on the prescription being dispensed monthly without the need to annotate as close control, but the proviso that the name of the residence or institution is included along with the patient NHI. [DHBs would cross match data as patients who leave a facility would not be eligible to continue to receive this automatic entitlement]. Dispensing frequency would not be less than 28 days.

Summary of change from current rule:

- *addition of penal institutions,*
- *no need to annotate CC as long as name of residence or institution is included, along with the patient NHI.*

2. Flexibility of dispensing periods for individual patients requiring initiation or dose adjustment; requiring a lesser amount to synchronise medications; or on a tri-cyclic antidepressant, an antipsychotic; a benzodiazepine; or a Class B Controlled Drug. The period of supply would be flexible.

Summary of change from current rule:

- *removal of Close Control for patients who are frail, infirm or unable to manage their medicines and replacement with services for eligible patients delivered via the*

⁴ Note currently more than two-thirds of Special Authority applications are made electronically and this is increasing monthly. The most used Patient Management Systems now have the ability to make electronic applications

proposed patient-centred system and DHB Long Term Conditions proposal (e.g. could include flexibility of dispensing periods, compliance packaging).

- *Retention of initiation or dose adjustment for specified medicines (for patients not covered by the DHB service proposals)*

3. Stock management – using Close Control to manage limited stock supply issues

No change to the current rule

The proposed new wording for the Close Control rule is attached as Appendix One.

Question 1:

- 1 a) **What comments do you have about the proposed Close Control rule changes?**
- 1 b) **Can you see how they work in with the 20 DHB service proposals?**
- 1 c) **Are there any gaps that could be created for any specific patients or groups?**

Question 2

- 2 a) **Given the significant changes to the Close Control rule, would it be more appropriate to rename the rule to avoid confusion?**
- 2 b) **Should there be a separate rule for people living in specified residences and institutions who would be able to receive monthly dispensing?**

Proposal Two: A patient-centred system for people with Long Term Conditions with objective, auditable Access Criteria and electronic Special Authority mechanism

Feedback to the 20 DHB and PHARMAC discussion documents showed strong interest in services that focused on the patient and his/her needs rather than medical conditions or prescribed medicines.

PHARMAC is proposing a patient-centred system which would be the gateway to the 20 DHBs Long Term Conditions Service for eligible patients living in the community. The service could be accessed through the patient meeting objective auditable access criteria selected via an electronic Special Authority that would be applied for either by the prescriber or the pharmacist (as a delegated multi-disciplinary team member). The patient would then be able to access adherence and compliance services that would be selected to best meet their needs. Services would be those currently provided under pharmacists' Annual Practising Certificates. They would not be new services, but services which are not currently explicitly recognised.

Access to the system and the Long Term Conditions Service would need to be tightly managed so that the patients who would most benefit based on objective criteria would be referred, and the funding could be managed. The incentives would need to be correctly aligned to avoid under- or over-servicing or "cherry picking" of patients.

How would services be accessed?

It is proposed that access to these services would be via an electronic Special Authority form that included objective, auditable access criteria to ensure the patient is within the eligible group and enabled the applicant to select from a suite of services to meet the patient's particular needs, consistent with the expectations contained in the 20 DHBs Long Term Conditions service expectations.

It is envisaged that the same review periods that currently apply for a Special Authority would apply to this Special Authority – usually 2 years.

It is expected that the Special Authority process would be less onerous for a prescriber, compared to the regular transactional compliance and script discussions that occur between prescribers and pharmacists. It would change the emphasis from Close Control (which prescribers said was not well known to them and largely driven by pharmacists) to a system known to prescribers, and would decrease the perception that pharmacists mostly contact prescribers for financial reasons. Most

electronic Special Authority applications can be made in less than 1 minute. A tick box format might help the system to be straightforward. It is also possible that the Patient-centred Special Authority could replace or become an umbrella for medicine-specific Special Authorities.

There are some technical and logistical issues that would need to be addressed before implementing the proposed patient-centred Special Authority. We have identified the following requirements:

- All pharmacies would need to be technically capable of applying for online Special Authorities, including being connected to the online system in real-time, and ideally have access to an automatic Special Authority look-up facility;
- The Ministry of Health's Sector Services systems would need to be technically capable and able manage the (initial) volume, unless some grand-parenting arrangements applied, with a review cycle to stagger change from the current to new system;
- Education/communication with all applicants including GPs and specialists to understand how the system would work;
- Agreement on how to manage back-up systems in the event of system outages;
- Agreeing how the system would come on line – to manage logistical risks on pharmacy and clinician workload and potential system overload.

Question 3

- 3 a) What comments do you have about how the services would be accessed?**
- 3 b) Are there other options than a Special Authority that might be more effective? Please outline your views**
- 3 c) Do you think this process will reduce transactional activities between prescribers and pharmacists and improve professional relationships?**
- 3 d) What comments do you have about the implementation issues and are there others you think need to be considered?**

Who could apply to access the services?

It is proposed that the Special Authority would be applied for by a primary care prescriber with whom a patient is enrolled as their usual provider of first level services⁵. Primary Care teams are the coordination point and continuity of care provider for a patient. Secondary care prescribers could provide advice to the patient's usual primary care provider, but would not be able to apply for the Special Authority in the first phase of implementation.

⁵ First Level Services: Primary Health Care services provided to an enrolled population or casual users by (ideally teams comprising) a medical practitioner / registered nurse / other health professional who has appropriate training and/or qualifications.

The prescriber (or pharmacy with explicit delegation as part of a collaborative multi-disciplinary team) could choose the appropriate service/s from a list on the Special Authority form. Prescribers and pharmacy will have mutually supportive knowledge of the patient's needs that can be drawn upon to determine which services will be most beneficial to the patient.

Question 4

- 4 a) What comments do you have about who could apply to access the services?**
- 4 b) Please provide feedback about whether a community pharmacy should be able to apply for the Special Authority and how possible perceptions of a financial conflict of interest could be managed?**

Who could provide the services?

Services would be delivered by a named community pharmacy, nominated by the patient, working in collaboration with an appropriately qualified (primary care) prescriber working within their scope of practice and in accordance with the 20 DHBs Long Term Conditions service. It is expected that the prescriber would be involved with one or more of the following: a general practice or integrated family health centre linked to a primary healthcare organisation or alliance multidisciplinary team, or other service/provider recognised by the DHB of service, e.g. nurse practitioner.

The proposed wording has been drafted to ensure that the services provided by community pharmacy can be delivered as part of sector developments such *Better, Sooner, More Convenient Services* and *Integrated Family Healthcare Centres*.

A patient would be asked to nominate a community pharmacy that they would attend to receive all their medicine management services. Where a patient wished to change their nominated pharmacy there would be no barriers to doing so and the funding would follow the patient. However, there may need to be some rules around a patient accessing more than one pharmacy or changing pharmacies frequently so that the service, continuity of care, and multidisciplinary team aspects of the proposal can be fully realised.

Question 5

- 5 a) What comments do you have about who could provide the services?**
- 5 b) What suggestions do you have to manage patients changing pharmacy?
For example, should the services only be available from one pharmacy for a defined period of time; should the patient pay more if they change pharmacies?**

Which patients would be eligible for the services, and Access Criteria?

It is proposed that eligible patients would be those living in the community who meet agreed access criteria related to having Long Term Conditions and needing support to manage their medicines and adhere to their treatment regime.

The proposed Access Criteria are set out below:

a) *Patient characteristics*

The patient must be able to demonstrate that they must have:

- Life long disability/ies and/or personal health co-morbidities; and
- Evidence of diminished capacity to self-manage medications, or evidence that the patient's caregiver/support person requires additional input and support to ensure medications are taken as prescribed; and
- Sub-optimal health requires increased patient contact with multidisciplinary team including the pharmacy team, as evidenced by one or more of the following: multiple hospital admissions in the past 12 months, frequent medication and dose changes [primary or secondary care] , within end of life stage, requiring palliative care; and/or
- Cultural or social characteristics such as English as a second language, cultural beliefs and attitudes to medication or treatment that may reduce compliance.

b) *Condition characteristics*

- Number and type of co-morbid long term conditions [at least 3 co-existing conditions for which the patient is medicated, or exceptional reasons if fewer than 3] e.g. CVD, diabetes, cancer, respiratory disease, mental health, alcohol and drug addiction.

c) *Medication characteristics*

- Numbers and types of medications that mean the patient would benefit from a synchronisation schedule to align dispensing dates and regular review (for example, review of drug interactions and/or dosage).

Question 6

6 a) What comments do you have about the proposed Access criteria?

6 b) Are there criteria which should be amended, added or deleted?

What are the proposed services?

The 20 DHBs Long Term Conditions proposal sets out the proposed overall service expectations for this group of high needs patients. Please refer to that proposal when you are reading this section. Note that these patients would no longer come within the Close Control rules, although frequency of dispensings may be one of the services selected.

Below are examples of what might be included in the services patients could receive from their pharmacist to support their compliance and adherence. The services would not need to be provided at every visit, but at sufficient intervals to be able to demonstrate patient benefit:

- multi disciplinary team involvement through the provision of information about patient adherence and pharmaceutical issues to the prescriber, or on admission to hospital.
- increased patient contact (e.g. phoning to check if the patient is taking medicine as required)
- synchronisation of medicines to align dispensing dates
- medicines screening and review⁶
- medicines reconciliation
- collaborative prescribing if permitted
- compliance packaging
- other auditable services to check if the patient is receiving and taking medicine as prescribed
- more frequent dispensings

These services are all within community pharmacists' current scope of practice.

Each service could have a claim code number attached, which would enable claiming through the usual Sector Services processes which would be fully auditable.

Question 7

7 a) What comments do you have about the proposed services?

7 b) What services you would add or delete?

⁶ Not Medicines Use Review or Medicines Therapy Assessment

Question 8

- 8 a) Should Proposals 1 and 2 be implemented as a single package or should there be a transition period?**
- 8 b) If you favour a transition period, what would the transition look like and how would the service and funding changes be managed without unduly affecting pharmacy?**
- 8 b) Should Proposals 1 and 2 be implemented nationally, regionally or in pilot sites?
Please provide reasons for your views?**

Proposal Three: Review of Schedule listings to ensure there is consistency of dispensing frequency across chemical groups where possible; and to review the listing rule that requires all new medications to be listed with monthly dispensing for an initial period of twelve months.

In the discussion document feedback stakeholders frequently raised concerns around inconsistencies in listings, especially with regard to iron supplements and psychiatric medicines. PHARMAC staff propose to review any inconsistencies and remedy them if appropriate. If it is considered that inconsistencies remain for valid reasons, then PHARMAC staff propose to explain the rationale to stakeholders as a News Story in the Update.

The current requirement “that all new chemicals listed on the Schedule from 1 October 2003 will not be listed in the stat list until they have been listed for at least 12 months” as resolved by PHARMAC Board in June 2003 is still applicable. The rationale was to enable PHARMAC to get usage data on new listings to determine whether there would be a wastage issue if they were dispensed in three-monthly lots. However, since the inception of stat dispensing in 2003 the cost of medicines has reduced so wastage for some new listings is no longer a financial risk. PHARMAC staff propose to review this rule to determine whether it could be modified for all or some new listings.

Question 9

9 a) What comments do you have on this proposal?

20 DHB Consultation Proposals

Proposal One: Patient-Centred Service for People with Long Term Conditions

This first proposal, for People with Long Term Conditions, links to PHARMAC's Patient-Centred Special Authority Proposal.

Service Description

PHARMAC is consulting on a Patient Centred system, including Access Criteria and a Special Authority mechanism. Please refer back to that proposal [Proposal 2, Questions 3 - 8], which would be the entry point to the services for patients with Long Term Conditions.

The key components of this proposed service are described in terms of a patient's journey. Many functions are performed now by many pharmacies without explicit recognition, because the current system focuses on medicines rather than patient needs; others such as electronic record sharing are widely desired but still aspirational, and being developed through pilot initiatives led by the National IT Board and others.

Key Components

1. The patient visits their primary care provider [general practice team]. The treatment plan identifies that the patient requires additional support for compliance and adherence with their medications
2. The provider applies for a Patient-centred Special Authority to initiate the Long Term Conditions service, setting out in the application the criteria the patient meets and identifying the pharmacy service options that would best assist the patient [e.g. dispensing frequency, compliance packaging]
3. General practice and pharmacy would each contribute information to the application and service options, and may seek information from other service providers who form part of the patient's multi-disciplinary team e.g. district nursing; home and community support provider
4. The patient nominates the community pharmacy they will attend to receive the services
5. The provider will send an (electronic) script or chart to the nominated pharmacy, and confirms the Special Authority number and services
6. The pharmacy enters this data into the patient's electronic pharmacy record [which ideally is a shared electronic health record, with e-prescribing facility]

7. The patient presents at the nominated pharmacy at a pre-arranged time for a medicines screening review and establishment of a synchronisation programme to align the patient's medications based on length of script, types of medications and patient needs
8. Medicines reconciliation [prescribed and OTC] will occur at the appropriate time
9. The pharmacy contacts the patient to let them know their script is available on the planned day agreed
10. The treatment plan, medications and the patient's compliance and adherence are reviewed by the provider and pharmacy at regular intervals, with the information shared if a single electronic patient record is not available
11. If the patient is admitted to hospital on a planned or acute basis, the patient's medication record will be provided [prescribed and OTC]. The patient will be encouraged to bring their medications in with them.
12. The hospital will record all medicines, including changes, in the hospital's electronic medical records
13. The hospital record will be transferred to the primary care provider/pharmacy with the intended date of patient discharge, along with a full discharge summary on the date of discharge, and the discharge plan for the multi-disciplinary team involved in the patient's community care e.g. District Nurse, home carer, GP, community pharmacy. For some new medicines, depending on time of discharge and patient domicile, it may be appropriate to discharge the patient with a discharge pack [2 -5 days supply].
14. The patient then re-engages with their primary care provider and pharmacy and their treatment regime or pharmacy service requirements are re-established or modified by agreement.

Question 10

- 10 a) Do you have any comments to inform the key components and expectations for this service?**
- 10 b) Which do you think are the most essential services and how could funding be targeted to them in an auditable way?**
- 10 c) What suggestions do you have to ensure that the services are not extended to patients outside the identified patient group and therefore cost more than the funding available?**

Funding the Service

In order to manage within the funding available, DHBs need confidence that only patients who meet the criteria receive the services; otherwise further budget management may be required.

It is proposed that this service would be funded through a combination of: current fee-for-service funding for these patients, funding released through PHARMAC's proposed changes to Close Control and a sustainable reduction in prescription volumes (which may be achievable by changing the incentives in the current system). Patient care would not be compromised, and introduction of the new services would need to be feasible within the funding available.

Several funding mechanism options for this service were suggested in the feedback on the discussion documents. They may not be mutually exclusive. DHBs do not have a preferred option and want to receive feedback on these and other possible options. The options put forward for consideration are:

- i. *A service fee per person* based on the patient-centred criteria (*same fee* for all patients)
- ii. *A service fee per person* based on the patient-centred criteria (*graduated fee* linked to patient service needs)
- iii. *Tiered fee*: an initial dispensing fee, then a lesser fee for subsequent dispensings within a defined period. Pharmacies would pack the full supply period at once and would be reimbursed for the drug cost of any uncollected packs. It may be necessary to implement rules so that no high-cost medicines could be included in these packs to avoid the risk of wastage. This tiered option could apply just to the service to patients with long term conditions, or could apply to all prescriptions.
- iv. *Service fee* which allows for one fee per medicine per month, packed and supplied weekly, with a medication management fee for weeks 2, 3, 4. This would allow the pharmacist to achieve efficiencies in packing and share the savings with the DHB.
- v. *Fixed service pool* [could be local, regional or national] within which each pharmacy's share of the pool is determined by the number of services it provides to patients. There could be a capped level of service provision per pharmacy to help ensure a fair distribution of the pool. A review process could potentially occur to enable pharmacies servicing relatively high needs patients to access a higher cap level. To manage DHBs' financial risks the fee-per-service item could be set at a lower level and the remainder of the pool paid to pharmacy through a end-of-year or quarter wash-up mechanism.

Question 11

- 11 a) Please comment on the funding options put forward.**
- 11 b) Identify whether you have a preferred mechanism(s), and the reasons for that preference.**
- 11c) Do you have any suggestions for alternative funding mechanisms?**
- 11d) Please comment on whether the tiered fee option [option iii] should be considered for all prescriptions, not just those relating to People with Long Term Conditions?**

Proposal Two: Provision of Pharmacy Services to People in Age Related Residential Care

Feedback on the 20 DHBs' November 2010 discussion document confirmed the general process for providing medicines to residents in Age Related Residential Care [ARRC] as follows:

- Practitioner assessment and pharmacist medicines reconciliation when the resident is admitted to the facility
- Practitioner visits and medication reviews at least 3 monthly; more frequently if required. The Practitioner can be contracted by the facility or individual resident. The PHO Agreement provides capitation funding for enrolled patients; the ARRC agreement requires the facility to have practitioners to service residents.
- The Practitioner charts medications on the resident's individual (usually paper-based) chart in the facility
- The chart is sent to the community pharmacy contracted by the facility
- The ARRC agreement provides for the facility to pay prescription charges, any manufacturer's surcharge and any package and delivery charge by the Pharmacist. Private paying residents have these costs met from the funding they pay the facility for their care⁷
- The Pharmacy Agreement provides for payment for medications (from the Community Pharmaceutical Budget] and fees to supply medicines monthly to all residents [publicly and privately funded]
- The community pharmacy checks the chart for dosages and interactions, and generates a script based on the chart which is sent to the practitioner to sign. The pharmacist is legally able to annotate the script items as close control (i.e., dispensed monthly rather than three monthly)
- The community pharmacy packs the medications for each individual and delivers them monthly to the facility, or more frequently if medications change during the period
- The community pharmacy submits an electronic claim which records all dispensings made against the pharmacy-generated script, backed up by the hard copy script received from the practitioner
- The community pharmacy may also provide a Bulk Supply Order to a licensed hospital (which some ARRC facilities offer)
- The community pharmacy may provide education, clinical advice and information to facility staff to assist their management of medications [e.g. Guidelines, Health and Disability Sector Standards; ARRC Agreement D19.2 Policy for Safe management and administration of medications, fall prevention practices]
- The community pharmacist usually does not engage directly with the individual resident

⁷ S139 Personal obligation to pay for care. Social Security (Long-term Residential Care) Amendment Act 2004 No 101

- The community pharmacist will engage as necessary with primary care and hospital practitioners regarding the treatment regime, review of prescribing, synchronisation of scripts and other matters as required

This Proposal is intended to more clearly state the service expectations for people in ARRC. PHARMAC's Proposal 1 is that people in ARRC would continue to receive monthly dispensings. These proposals may need to be mirrored in the Agreements DHBs have with providers involved in this multi-disciplinary team, namely the Community Pharmacy Agreement, ARRC Agreement and Primary Healthcare Agreement. The proposal also takes into account the Health and Disability Sector Standard and the revised Medicine Care Guides for Residential Aged Care, Medicines Management section [final draft January 2011].

Service Outline

The key elements and components for this ARRC service are within the scope of the current service expectations. However, the discussion document feedback revealed that there is variable provision now, with strong support for the service to be more clearly specified and consistently available. DHBs would like to achieve a more consistent service across New Zealand, and to ensure incentives are appropriately aligned for all parties and cost shifting is avoided. DHBs do not, as yet, have a preferred funding option for this service and invite comment on the service expectations, the funding options and on other questions set out in this proposal.

Key Elements:

1. Quality services to ARRC residents and facility staff based on established professional and quality management standards, guidelines and codes of practice.
2. Clinical advice for optimal Service User management, including information, advice and training support for facility staff, and input to the facility's Medicine Management policy.
3. A multi-disciplinary team approach, including collaborative, or delegating prescribing as permitted by legislation and professional competencies.
4. Agreement amongst the multi-disciplinary team about the mode of delivering medications to a particular Service User, depending on their personal capability and safety considerations. Medications may be in compliance packaging or in individual packaging.
5. Agreement amongst the multi-disciplinary team about the dispensing frequency which would generally be monthly (and paid on that basis), but could be more or less often, as agreed.
6. Medicines reconciliation and synchronisation.
7. Meeting administrative requirements.

Not included:

- a) Compliance Packaging and the delivery charge as these are included in the ARRC bed day price for publicly-funded residents or the fees paid by privately-funded residents

- b) Any other fees or arrangements currently paid between the ARRC facility and pharmacy e.g. out of hours
- c) Any other fees paid by individual residents for services not covered in contracted care services
- d) Engagement with general practice, which is paid through capitation payments made under the PHO Agreement, and/or or arrangements between the ARRC facility and GP.

Service Responsiveness

- a) Services to be provided a minimum of 5 days a week, with agreed arrangements for unavoidably urgent or emergency after hours services, or for services outside ordinary business hours and/or for more than 5 days a week
- b) Dispensing to occur for:
 - (i) non-urgent prescription items: during business hours at the agreed packaging cycle frequency
 - (ii) changes to non-urgent prescription items: at the next packaging cycle, unless the practitioner specifically requests an earlier dispensing
 - (iii) urgent prescription items: within one hour if they are being picked up from the pharmacy or within four hours if being delivered;

Service Processes

- (i) Establish systems and a policy/protocol for the distribution and administration of the medications with the ARRC facility that is available for everyone involved and funders and their agents (e.g. auditors)
- (ii) Prompt dispensing, supply and delivery of all pharmaceutical requirements (including medicines and compliance packaging options) at agreed times to the residence by a pharmacist or nominated employee known to the staff. Medicines will generally be delivered at agreed intervals depending on residents' capacity and capability, residence requirements, safety issues, efficient use of resources and avoiding unnecessary wastage. This is generally expected to be monthly, but could be more or less frequent by agreement. Where compliance packaging is used, any changes to non-urgent medication should be commenced at the packing cycle, unless specifically requested otherwise by the prescribing practitioner. Urgent medication requirements should be dispensed as soon as practicable to enable the treatment regime to commence. The supply function can be provided by a community pharmacy or, through agreed sub-contracting arrangements with a robotic packaging facility.
- (iii) Provide pharmaceutical advice and information, including medicine management, reconciliation, monitoring and review, medicines synchronisation, safe handling, storage, security, administration and dosage of medicines to facility staff, nursing and medical practitioners
- (iv) Engage and interact with members of the multidisciplinary team, including agreement about the medicines reconciliation process and regular medicine reviews that will occur

- (v) Maintain relevant and accurate details on medications, including a medication profile for every resident in accordance with statutory requirements, and make this available for use by staff, residents, the supplying pharmacy, doctors and relatives of residents of the facility, and if care transfers to another pharmacy, ARRC facility or secondary care
- (vi) Agree procedures for prescribing medicines by authorised practitioners and the system by which the prescriptions/orders are obtained, and the records kept, including a statement of confidentiality of residents' medical records
- (vii) Agree procedures for reporting significant findings to the prescriber, including problems with a particular prescription or pharmaceutical
- (viii) Monitor stocks held in the facility and be responsible for the removal and disposal of expired, discontinued and damaged medicines
- (ix) Visit the residence regularly as agreed with facility staff e.g. to deliver support services, information and education sessions to staff, and Service Users as appropriate
- (x) Supply medicines in packaging with clear labels and full directions for use, suitable for direct administration to the individual resident, with appropriate cautionary and advisory labels
- (xi) Ensure continuity of supply of medicines to residents who are being transferred or are temporarily absent
- (xii) A small stock of "household remedies" should be supplied, in consultation with medical practitioners and staff e.g. Paracetamol.

Question 12

12 a) Please provide comments on this service outline and the benefits perceived for people in ARRC

12 b) Are there any elements you think should be added, amended or deleted, and, if so, why?

Pharmacy Agreement Considerations

Not all community pharmacies provide services to ARRC, and there is movement in those pharmacies who do provide services. Some pharmacies specialise in this area and may have robotic packaging facilities, or supply from a remote location. DHBs would want to ensure that contracting options remain as flexible as they currently are, whilst proposing that the service focus has primacy, rather than the supply function.

DHBs currently have the contractual right to agree sub-contracting options, and out-of-district service options and they would propose that this continues so that regular, personal, on site services are available to the facility and residents.

DHBs are interested in contracting options that support policy initiatives such as *Better Sooner More Convenient Services*, and allow efficiencies in the system to be developed. This means that DHBs will be open to community pharmacy working with others such as:

- I. A Pharmacy Group, co-operative wholesaler and/or robotic packaging facilities
- II. A PHO or Integrated Family Health Centre
- III. An Alliance Group who could deliver some or all services to the facility or sub-contract them
- IV. An ARRC Facility or Facility Group.

The ARRC Primary Health Care Organisation and/or Alliance Agreements could mirror the pharmacy service requirements, as outlined in the service description, to residents so that the expectations of all parties are clear.

Question 13

13 a) Please provide comments about the Pharmacy Agreement options

13 b) Please provide comment about changes that would be needed to the ARRC, Primary Health Care Organisation and/or Alliance Agreements

Funding the Service

DHBs can identify people in ARRC facilities [whether publicly or privately funded] and therefore expenditure on pharmacy services can be budgeted with a high degree of accuracy.

PHARMAC's consultation proposal is for all people in ARRC to have monthly dispensing for all medicines. Facilities would pay for packaging and delivery for patients, as is currently required in the ARRC Agreement for publicly funded residents or in the arrangements with privately funded residents.

Funding mechanism options for this service include:

- o A service fee per person per month: same fee for all patients; or
- o A service fee per person per month: graduated fee depending on patient need (e.g. bed type) and service requirements; or
- o A facility fee based on average occupancy; or
- o Fee-for-service for each prescription item as currently.

Question 14

14 a) Please comment on how the service might be funded, including a preferred mechanism?

14 b) Do you have any suggestions for alternative funding mechanisms?

Proposal Three: Provision of Pharmacy Services to People with Disabilities in Community Residential Support Services

It proved difficult to engage as fully as we would have liked with people with intellectual, mental health and physical disabilities, providers and caregivers in community residential support services, during the discussion document phase in November-December 2010 and with community pharmacy.

Available information and literature showed that these service users often have compromised morbidity and mortality and may be on multiple medications related to their disabilities and personal health conditions. They would benefit from additional support similar to that required by people in ARRC, particularly in the areas of medication review and management.

The Disability and Mental Health philosophies are similar: live an ordinary life [Disability] and opportunities to participate in everyday life [Mental Health]. Services Users in residences will be in small home-like residences of 5-6 beds, which may have different levels of support over a 24 hour period from community support workers. Very few will have clinical staff on site, and so compliance packaging is needed in most instances for safe dispensing. The size of the residences means they come within the ambit of the Health and Disability Sector Standard.

Service Users with Intellectual Disabilities are currently able to receive their medications monthly under the Pharmaceutical Schedule close control rules, and the rules contain provisions relating to close control for some mental health medications.

Process

The usual process for a Service User now is:

- a) The Service User (person with disability) registers with a primary care practitioner as their regular provider of urgent and non-urgent primary health services and is enrolled in a PHO
- b) The Practitioner writes a prescription form itemising the pharmaceuticals the Service User requires and reviews medication as necessary. Scripts are usually written three monthly, although some items may be categorised as close control (daily, weekly or monthly) where the Service User has particular needs, such as an intellectual disability (currently monthly close control permitted by Pharmaceutical Schedule rules) or some mental health or alcohol and drug medications (e.g. methadone)
- c) The Service User, or their agent (e.g. support worker) takes the scripts to the community pharmacy either they or the residence choose

- d) The community pharmacist checks the scripts, packs the medications and provides them directly to the resident and/or their support worker, along with necessary information and advice [to the Service User, and/or residence staff to assist the management of medications]. In some cases, the pharmacist will pack and deliver medications to the residence. Some residences may have specific packaging requirements which they pay for e.g. compliance/blister packaging.
- e) The Service User pays the co-payment and any part charges for the scripts. However, Service Users who used to live at Templeton or Kimberley before being deinstitutionalised are exempt from co-payments
- f) The community pharmacist will engage as necessary with the primary and secondary care practitioners about the treatment regime, synchronisation of scripts and other clinical or service matters.

Proposal

This proposal concentrates on aspects covered by the contractual relationships between DHBs and community pharmacy; DHBs and community mental health residences; MOH and community disability residential providers; DHBs and primary care through the PHO Agreement and the ownership relationship between DHBs and their hospital providers.

Aspects related to the Pharmaceutical Schedule are covered in the parallel PHARMAC consultation proposal document. The proposal also takes into account the Health and Disability Sector Standard requirements.

Service Outline

The key elements of the proposed service are in line with those currently expected. Feedback received on the discussion document showed that the service may not be consistently offered, and DHBs see benefits to more clearly setting out nationally consistent expectations. The elements are set out below:

1. Quality services to residents and residences staff based on established professional and quality management standards, guidelines and codes of practice
2. Clinical advice for optimal resident management, including information, advice and training support for facility staff, and input into the facility's Medicine Management policy
3. A multi-disciplinary team approach, including collaborative, or delegating prescribing as permitted by legislation and professional competencies
4. Agreement amongst the multi-disciplinary team about the mode of delivering medications to a particular Service User, depending on their personal capability and safety considerations. Medications may be in compliance packaging or in individual packaging

5. Agreement amongst the multi-disciplinary team about the dispensing frequency which would generally be monthly (and paid on this basis) but could be more or less often, as agreed
6. Medicines screening, synchronisation and reconciliation
7. Meeting administrative requirements.

Not included in these services are:

- i. Compliance Packaging [at present, the policy or contract settings are that, if needed, these are paid by the resident or the residence]
- ii. Any other fees or arrangements currently paid between the residence and pharmacy e.g. out of hours
- iii. Any other fees paid by individual residents
- iv. Engagement with the GP [part of PHO Agreement capitation payments, or arrangements between the residence and GP].

Service Responsiveness

- a) Services to be provided a minimum of 5 days a week, with agreed arrangements for unavoidably urgent or emergency after hours services, or for services outside ordinary business hours and/or for more than 5 days a week. In most instances Service Users or their support workers will see the pharmacist during ordinary opening hours
- b) Dispensing to occur as for the Base Pharmacy Services Agreement.

Service Processes

- i. Establish systems and a policy/protocol for the distribution and administration of the medications with the residence that is available for everyone involved and funders and their agents (e.g. auditors)
- ii. Prompt, accurate dispensing, supply and delivery of all pharmaceutical requirements (including medicines and compliance packaging options) at agreed times to the residents. Medicines will generally be supplied at the pharmacy, generally monthly, but can be more or less frequent by agreement. Where compliance packaging is used, any changes to non-urgent medication should be commenced at the packing cycle, unless specifically requested otherwise by the prescribing practitioner. Urgent medication requirements should be dispensed as soon as practicable to enable the treatment regime to commence. The supply function can be provided by a community pharmacy or, through agreed sub-contracting arrangements with a robotic packaging facility
- iii. Provide pharmaceutical advice and information to residence and nursing staff and medical practitioners, including on medicine management, reconciliation, monitoring and review, medicines synchronisation, safe handling, storage, security, and administration and dosage of medicines

- iv. Engage and interact with members of the multidisciplinary team, including agreement about the medicines reconciliation process and regular medicine reviews that will occur
- v. Maintain relevant and accurate details on medications, including a medication profile for every resident in accordance with statutory requirements, and make this available for use by staff, residents, the supplying pharmacy, doctors and relatives of residents of the residence, and if care transfers to another pharmacy, residence or secondary care
- vi. Agree procedures for prescribing medicines by authorised practitioners and the system by which the prescriptions/orders are obtained, and the records kept, including a statement of confidentiality of residents' medical records
- vii. Agree procedures for reporting significant findings to the prescriber, including problems with a particular prescription or pharmaceutical
- viii. Monitor stocks held in the residence and be responsible for the removal and disposal of expired, discontinued and damaged medicines
- ix. Visit the residence as agreed with residence staff e.g. to deliver support services and information and education sessions to staff, and provide information to Service Users as appropriate
- x. Supply medicines in packaging with clear labels and full directions for use suitable for direct administration to the individual resident, and appropriate cautionary and advisory labels
- xi. Ensure continuity of supply of medicines to residents who are being transferred or are temporarily absent
- xii. A small stock of "household remedies" should be supplied, in consultation with medical practitioners and staff, e.g Paracetamol
- xiii. Ensure that wastage of medications is minimised.

Question 15

15 a) Please provide comments on this service outline and the benefits perceived for people in community mental health and intellectual disability residences

15 b) Are there any elements you think should be added, amended or deleted, and, if so, why?

Pharmacy Agreement Considerations

Not all community pharmacies provide services to disability community residents/residences, and there is movement in those pharmacies who do provide services. DHBs want to ensure that contracting options remain as flexible as they currently are but propose that the service focus has primacy, rather than the supply function.

DHBs currently have the contractual right to agree sub-contracting options, and out-of-district service options and they propose that this continues so that regular, personal, services are available to the residents and residence staff.

DHBs are interested in contracting options that support policy initiatives such as *Better Sooner More Convenient Services*, and allow efficiencies in the system to be developed. This means that DHBs will be open to community pharmacy working with others such as

- a) A Pharmacy Group, co-operative wholesaler and/or robotic packaging facilities
- b) A PHO or Integrated Family Health Centre
- c) An Alliance Group who could deliver some or all services to the facility or sub-contract them
- d) A Mental Health or Intellectual Disability Provider Group.

The Mental Health or Intellectual Disability Residence, Primary Health Care Organisation and/or Alliance Agreements could mirror the pharmacy service requirements, as outlined in the service description, to residents so that the expectations of all parties are clear.

Question 16

16 a) Please provide comments about the Pharmacy Agreement options

16 b) Please provide comment about changes that would be needed to the Intellectual Disability or Mental Health Residence, Primary Health Care Organisation and/or Alliance Agreements

Funding the Service

DHBs believe they identify accurate data on residents' expenditure on pharmacy services and can budget with a high degree of accuracy.

PHARMAC's consultation proposal is for all people in community mental health and intellectual disability residences to have monthly dispensing for all medicines. Residences would continue to pay for packaging, and delivery if required.

Funding mechanism options for this service include:

- o A service fee per person per month: same fee for all patients; or
- o A service fee per person per month: graduated fee depending on patient need (e.g. bed type) and service requirements; or
- o A facility fee based on average occupancy.

- Fee-for-service for each prescription item as currently.

DHBs propose to achieve a more consistent service across New Zealand, and to ensure incentives are appropriately aligned for all parties and cost shifting is avoided. DHBs do not, as yet, have a preferred funding option for this service.

Question 17

17 a) Please comment on how the service might be funded, including a preferred mechanism?

17 b) Do you have any suggestions for alternative funding mechanisms?

Appendix 1: Proposed Close Control wording

“Close Control” means the dispensing of a Community Pharmaceutical, in accordance with a Prescription, in quantities less than one 90 Day Lot (or for oral contraceptives, less than one 180 Day Lot) for a Community Pharmaceutical referred to in Section F Part I, or in quantities less than a Monthly Lot for any other Community Pharmaceutical, where any of a), or b) or c) apply.

- a)** All of the following conditions are met:
- 1) the Community Pharmaceutical has been prescribed for a patient who:
 - i. resides in a penal institution; or
 - ii. is intellectually or mentally disabled and resides in a community residential care facility; or
 - iii. has an age-related disability and resides in an age related residential care facility; and
 - 2) the quantity or period of supply to be dispensed at any one time is not less than 28 days' supply; and
 - 3) the prescribing Practitioner or Pharmacist has:
 - i. written the name of the Institution or facility on the prescription; and
 - ii. endorsed the Prescription clearly with the words “close control” or “CC” (this applies to all medicines prescribed on the prescription); and
 - iii. initialled the endorsement/annotation in their own handwriting; and
 - iv. specified the maximum quantity or period of supply to be dispensed at any one time.
- b)** All of the following conditions are met:
- 1) the Community Pharmaceutical has been prescribed for a patient who:
 - i. requires close monitoring due to recent initiation onto, or dose change for, the Community Pharmaceutical (applicable to the patient's first changed Prescription only); and
 - ii. requires that Community Pharmaceutical to be dispensed in a smaller quantity than that for which it is currently funded, or
 - iii. the Community Pharmaceutical is any of the following:
 - a. a tri-cyclic antidepressant; or
 - b. an antipsychotic; or
 - c. a benzodiazepine; or
 - d. a Class B Controlled Drug; and
 - 2) the prescribing Practitioner has:
 - i) endorsed each Community Pharmaceutical on the Prescription clearly with the words “close control” or “CC”; and

- ii) initialled the endorsement in their own handwriting; and
 - iii) specified the maximum quantity or period of supply to be dispensed at any one time.
- c)** All of the following conditions are met:
- i) where PHARMAC has approved and notified pharmacists to annotate prescriptions for a specified Community Pharmaceutical(s) “Close Control” without prescriber endorsement for a specified time; and
 - ii) the dispensing pharmacist has:
 - a. clearly annotated each of the approved Community Pharmaceuticals that appear on the prescription with the words “close control” or “CC”; and
 - b. initialled the annotation in their own handwriting; and
 - c. specified the maximum quantity or period of supply to be dispensed at any one time, as specified by PHARMAC at the time of notification.

RICO’s suggestions [to be confirmed]

The schedule specifies for (community patients) a default length of dispensing (monthly/ 3 monthly) for each pharmaceutical.

Prescribers can request and pharmacists may dispense a higher dispensing frequency in the following circumstances, either:

- 1) the Community Pharmaceutical is any of the following:
 - 1. a tri-cyclic antidepressant; or
 - 2. an antipsychotic; or
 - 3. a benzodiazepine; or
 - 4. a Class B Controlled Drug; and

Or:

- 2) the Community Pharmaceutical has been prescribed for a patient who:
 - i. requires close monitoring due to recent initiation onto, or dose change for, the Community Pharmaceutical (applicable to the patient’s first changed Prescription only); and
 - ii. requires that Community Pharmaceutical to be dispensed in a smaller quantity than that for which it is currently funded

and:

- 3) the prescribing Practitioner has endorsed each Community Pharmaceutical on the Prescription clearly with the words “close control” or “CC” and;
- 4) initialled the endorsement in their own handwriting; and
- 5) specified the maximum quantity or period of supply to be dispensed at any one time

Note that the ability to endorse and dispense only applies to pharmaceuticals listed under 1) or 2)

Pharmacists can dispense at a higher frequency if:

- b) required to do so by the medicines act or under the medicines regulations or;
- c) permitted through the pharmacy contract or schedule as part of a patient centric service or;
- c) All of the following conditions are met:
 - i) where PHARMAC has approved and notified pharmacists to annotate prescriptions for a specified Community Pharmaceutical(s) "Close Control" without prescriber endorsement for a specified time; and
 - ii) the dispensing pharmacist has:
 - a) clearly annotated each of the approved Community Pharmaceuticals that appear on the prescription with the words "close control" or "CC"; and
 - b) initialled the annotation in their own handwriting; and
 - c) specified the maximum quantity or period of supply to be dispensed at any one time, as specified by PHARMAC at the time of notification.

Prescribers can request (and pharmacist must dispense) at a lower dispensing frequency if:

- a) **the pharmaceutical is not marked with a * in the schedule and**
- b) **the prescription has been endorsed certified exemption**

For patients in institutions the following rules apply:

- a. the Community Pharmaceutical has been prescribed for a patient who:
 - i. resides in a penal institution; or
 - ii. is intellectually or mentally disabled and resides in a community residential care facility; or
 - iii. has an age-related disability and resides in an age related residential care facility; and
- b. the quantity or period of supply to be dispensed at any one time is not less than 28 days' supply.