

# PHARMAC & 20 DHBs Consultation Proposals

## Pharmaceutical Schedule Rules

## Community Pharmacy Services

February 2011

### How to give feedback

The questions in this form are taken from the consultation proposals related to the Pharmaceutical Schedule Rules and Community Pharmacy Services. The format is designed to assist respondents provide their feedback to the proposals.

Please note that you do not have to provide personal information if you would prefer not to.

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You are making this submission:

- As an individual
- On behalf of a group or organisation *(please specify)* **On behalf of The Northern Region DHBs**.....  
Number of people in the group or organisation?.....
- Other *(please specify)* .....

Please tick which description best suits you or your organisation:

- |   |   |
|---|---|
| <input type="checkbox"/> Community Pharmacy                           | <input type="checkbox"/> Non-government Organisation      |
| <input type="checkbox"/> Community Mental Health Provider             | <input type="checkbox"/> Intellectual Disability Provider |
| <input type="checkbox"/> Age Related Residential Care Provider        | <input type="checkbox"/> <b>District Health Board</b>     |
| <input type="checkbox"/> Professional Organisation                    | <input type="checkbox"/> Government Agency                |
| <input type="checkbox"/> Consumer Advocacy Organisation               | <input type="checkbox"/> Consumer                         |
| <input type="checkbox"/> Primary Health Organisation/General Practice |   |
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## Official Information Act requirements

Your submission may be requested under the Official Information Act 1982. If your submission is requested, the 20 DHBs and PHARMAC will release your submission to the person who requested it. If you are an individual as opposed to an organisation, the 20 DHBs and PHARMAC will remove your personal details from the submission if you check the following:

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

**The deadline for feedback is 5pm Friday 18 March 2011.**

Submissions are required in written form. Please send your submission to:

**Email:**            [pharmacycommunity@dhbz.org.nz](mailto:pharmacycommunity@dhbz.org.nz)

**OR    Post:**  
Community Pharmacy Consultation Proposals  
c/- PHARMAC  
PO Box 10-254, Wellington 6143  
Attention: Janice Donaldson

**OR    Fax:**    04 460 4995  
Community Pharmacy Consultation Proposals  
Attention: Janice Donaldson

## Consultation Questions

These questions are contained in the Pharmacy Consultation document which has been circulated with this question and answer response sheet.

You can expand the boxes so that your response can cover all the matters you wish to raise.

## PHARMAC Proposals

### Proposal One: Close Control Rule Changes

#### Question 1

1 a) What comments do you have about the proposed Close Control rule changes?

While we generally do not oppose the addition of penal institutions to those who require close control, it is difficult to know the impact of this without fully understanding what the system in place at present is, the rationale for change, or what the cost implications are.

There has been no financial modelling to ascertain the financial impacts of adding prisons to the close control dispensing rule. It does not appear that other changes to close control rules will release much funding. Would there be an associated transfer of funding across from the corrections budget to DHB community pharmacy budgets to cover any increased cost to DHBs, and if such a transfer were to occur would it be allocated on a PBF basis or on a per capita basis?

DHBs do not have the facility to cross match data as patients leave institutions, it is envisioned that when this happens that a new script would be issued as normal through primary care channels and dispensed as normal.

Although we are generally supportive of the concept of Residential Facilities automatically attracting close control status, we would seek clarity as to the rationale for all patients in residential care having this rule applied.

The removal of bureaucracy of annotation is welcome, but we note the appendix still states that the CC annotation must be added.

The term 'frail, infirm or unable to manage their medicines' is a loose definition that was open to interpretation by both prescriber and pharmacists, we support the removal of this definition

to avoid the potential for confusion.

We suggest that the period of close control for initiation of treatment or dose adjustment be limited to, e.g. 3/12.

There are concerns that prescribers currently do not have a full understanding of the 'close control' process and that these changes may add to the confusion. There needs to be associated training for prescribers, and where possible a simplification of the process to enable pharmacists to better manage patients medication.

If the proposed close control changes are introduced it is likely that there will be an initial increase in stock levels required to be held by pharmacies, with an associated short-term increase in pharmacy costs as more medicines become stat. This may cause stock-management difficulties for some pharmacies.

1 b) Can you see how they work in with the 20 DHB service proposals?

The 20 DHBs proposal states that dispensing for those in ARRC could be more or less frequently than monthly but PHARMAC's proposals states that it will not be less than 28 days. There needs to be alignment between the proposals in this regard.

1 c) Are there any gaps that could be created for any specific patients or groups?

The criteria for the patient-centric SA needs to capture the appropriate patient population. At this stage it is unclear whether there will be gaps.

Controlled drugs (Class B) need to be considered as a separate entity. They cannot be managed on a 28 day cycle, and in preference should be managed on a 7 day cycle and legislated this way. The current 10-day prescribing for Controlled drugs class B does not work in compliance packaging.

For other classes, e.g. tricyclic antidepressant, antipsychotics, benzodiazepines, the period of supply should be assessed individually, and all medicines for that individual supplied on the same basis, i.e. if a patient is stable on a tricyclic used for pain there is no need for this medicine to be dispensed monthly when all their other medicines are dispensed 3-monthly – for some it actually increases non-compliance because the patient forgets or finds it inconvenient to pick them up monthly and may go for several weeks without before deciding their pain has become intolerable again.

**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?

The monthly dispensing of medications in institutions could be renamed 'institutional/residential dispensing' to avoid confusion with close control as their purposes are different.

2 b) Should there be a separate rule for people living in specified residences and institutions who would be able to receive monthly dispensing?

Yes. There should be a separate and appropriately named rule (as recommended above) for those in institutions, while close control is the rule which continues to apply where the purpose is greater supervision.

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

**Question 3**

3 a) What comments do you have about how the services would be accessed?

The introduction of a special authority may reduce the number of solicited annotations on prescriptions by pharmacists to GPs.

It needs to be minimally bureaucratic/efficient and fully auditable. If this is the case, then there would be no need to restrict applications to general practice teams, i.e. community pharmacists could apply for these services.

There also needs to be allowances for high-risk patients who do not visit the GPs for care, i.e. there should be an allowance made so secondary care physicians can apply for the SAs.

3 b) Are there other options than a Special Authority that might be more effective? Please outline your views

Not at this juncture.

3 c) Do you think this process will reduce transactional activities between prescribers and pharmacists and improve professional relationships?

Yes, but there could be additional work created from the follow-up of expired SAs, especially for pharmacists. However, at a clinical level that may contribute to improve relationships between pharmacists and general practice in some cases which can only be positive.

3 d) What comments do you have about the implementation issues and are there others you think need to be considered?

Primary care teams would require an adequate lead in time to set appropriate processes and system to be able to apply for SA for those who require these services.

Pharmacists will also need a transitional period so where appropriate patients who are currently under close control are not just taken off and where appropriate are referred back to the GP for an SA application and for others to be transitioned off where possible; this would

require careful management.

A dual system may need to be in place for a period of 6 months. The administrative burden of this change will need to be acknowledged and transition supported wherever possible.

Joint education of pharmacists and primary care (preferably together) would support the proposed change, particularly in establishing a collegial approach to this service – both professions are important in ensuring the service is optimised for a patient – the pharmacist in helping identify patients and then delivering services agreed with the GP team and reporting back to the GP team by being able to add to the GP patient record, and the GP team in following up with the patient at their next visit based on the feedback from the pharmacist. It should be possible for pharmacists to access patient records to view at a minimum the problem list and the medication list. This information should become part of TestSafe or similar just as is intended for dispensing history. Is TestSafe the repository by which the pharmacist could send information for inclusion in the patient record?

**CMDHB view:**

Albeit the proposed overall service specification (p19) states that medicines screening and review is not MUR, all of the services specified within this suite are those contained in the Counties Manukau DHB Service Specifications for MUR/MSD services.

This raises a number of issues:

1. A definition of the service involved in medicines screening and review is needed together with consideration as to whether this is indeed part of the suite of services that every pharmacy can provide or whether it is only available via an accredited pharmacist as part of an MUR or MTA process;
2. It is essential to explain how this suite of services as a service group differs from MUR and when it would be appropriate to use one in preference to the other.
3. The total quantum of funding allocated to the suite of services should not be more than DHBs are currently paying for MUR given that a higher competency is required to deliver MUR. CMDHB pays \$200 for a complete one year MUR episode of care.

**Question 4**

4 a) What comments do you have about who could apply to access the services?

The proposal states that a pharmacist could apply for these services on behalf of a patient as part of a multi-disciplinary team which we support in principle, however the prescriber/pharmacists relationship is not at a formal level or consistent across the sector so we are unsure given that how this responsibility could be explicitly delegated without a truly

multi-disciplinary team structure.

For those DHBs with low CC rates, the affordability of this proposal is uncertain.

Many patients fall through the cracks between primary and secondary care. DHB provider arms are becoming quite sophisticated at identifying their 'frequent flyers' or 'very high intensity users'. LTC patients who might benefit from adherence services are often pinpointed in hospital by the medicine reconciliation on admission and/or by the ward pharmacist, nurse or doctor involved in the discharge planning. To limit the application for special authority to the primary care prescriber will mean that a huge opportunity is lost in identifying these patients and, more particularly, in offering services at a vulnerable point in their care when they most need support on a new/revised drug regimen. Secondary care must at least have the opportunity to get some immediate services for appropriate patients on discharge.

**CMDHB view:**

The suite of services included is both comprehensive and intensive, as mentioned previously, more in line with what is expected from a MUR service. This is not consistent with the intention that the services be a) within the capability of all community pharmacists without further training b) within the likely funding that will be available from the dispensing pool to fund these services. CMDHB as a particular problem.

South Auckland currently has relatively low rates of close control by national standards. On the other hand it has a very large population of patients with long term conditions fitting the broad criteria for the LTC service suite as currently proposed compared with many DHBs. CMDHB is therefore concerned as to how it will be able to fund these services on the basis of the funding transfers proposed without adequate controls on access to these services.

CMDHB perceives significant risks in controlling its pharms budget unless it is able to control the numbers eligible for these services. This may need to be managed by capping the number of patients who may receive services in any financial year based on a formula reflective of disparity by PHO or GP practices.

The proposals are simply not feasible in their current form as they pose an unacceptable risk for both funders and providers.

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?

Conflicts of interest are very common amongst all providers of health services. In this situation it is not just pharmacists but also general practitioners who may have a financial conflict of interest. What is required to manage conflicts of interest for both doctors and community pharmacists are:

1. auditable criteria for access
2. willingness to conduct regular audits of community pharmacies and medical practitioners
3. willingness to take steps to manage providers who are not following the criteria for access.

If community pharmacists cannot apply for an SA, the process will impact the GPs workload. In a team environment shared responsibility is to be encouraged.

**NDHB view:**

Secondary care providers (hospital doctors, hospital nurses, hospital pharmacists, community nurses visiting patients in the home) need to be able to refer patients into the service in a timely manner (immediately on discharge or very soon after). They should not be forced to wait for a consultation with the GP before the service can be provided – the patients will only continue to fall through the gap (chasm) that currently exists for our highest risk patients. The community pharmacy is usually the first health professional that a patient sees on discharge and community pharmacists often realise that some patients need more support than is currently provided because of current funding.

**Question 5**

5 a) What comments do you have about who could provide the services?

For vulnerable people with high health needs nominating a pharmacy would help the patient receive better service and continuity of care in line with the intent of the proposals. However, there needs to be flexibility to allow patients to change pharmacies, e.g. if they move area.

The proposal as it stands lacks detail as to what the rules would be around changing pharmacies. It needs to be clear that the services will be within the routine scope of pharmacy practice, and that they are not over and above these competencies.

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?

The ease with which the service can be transitioned from one pharmacy to another will

depend to a large extent on the funding model. During introduction of the service it is recommended that patients who have selected a pharmacy for this service should lose their eligibility if they change pharmacies except where they are changing GPs. A patient transferring doctors would need their new enrolled provider to reapply on their behalf after reviewing their needs.

Whatever the mechanism, it needs to support continuity of care and maintenance of adherence, and without any financial penalties for patients.

Patients need to have the ability to change e.g. if not happy with service. This almost requires an 'enrolment' process with a pharmacy and a change process when a patient wants to change pharmacies, just in the same way that patients are currently enrolled with the general practice.

**Question 6**

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

The access criteria are insufficiently specific at this point to conceive of a system that could be successfully targeted to key high need patient within the likely funding available. A scored prioritization tool for determining the need for pharmacist intervention might be useful.

More work is needed to ensure the criteria are adequate for targeting patients who may require this care. We would want to see evidence that the criteria will cover the population who require these services.

We agree with the provisions in the proposal relating to the importance of supporting people with low literacy and the measure that acknowledge the cultural aspects of care.

**NDHB view:**

The aim of the programme is to develop a patient centric approach to management, so to include medication characteristics appears to be a move back towards a medicine centric approach. Medication characteristics could be concluded under patient characteristics i.e. becomes part of the analysis of the patient's ability to self manage. Similarly condition characteristics could become part of assessing patient co-morbidities under patient characteristics. It is important that the system is patient-centric and not revert to condition or medicine-centric – the patient needs to be assessed as a whole including social factors.

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

The current criteria need to be clearer to ensure they meet the needs of patients.

**Question 7**

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

Do the GPs want formal feedback from the pharmacists about the patient's adherence and pharmaceutical issues? The intent of the proposal is to encourage pharmacy as part of the multi-disciplinary primary care team, however the inclusion of 'snippets' of information sharing without a larger context or consultation with the wider primary care team will not further this goal.

Medicines screening and review is vague as a service option and would require greater clarity to ensure that it is clearly delineated from the enhanced service delivery which is medicines utilisation review.

The list of services are those services that pharmacists should currently be providing under their APC, therefore why is additional funding being attached to this practice? This is pharmacists being paid for services that they could be providing already as part of BAU but in recognition of their contribution that they are providing to their patients. However, it is of concern what funding these services may attract if there is no give in other services elsewhere. We need further financial analysis to ascertain the risk and audit

Depending on the financials of this service the accessibility to number of systems should be limited, what evidence is there that these services support patients with LTCs better than currently... how does this all align with MUR which is a separately funded service which has demonstrable evidence for success as evidenced in international literature?

**CMDHB view:**

The objective of the services proposed is supported however the number of critical unknowns at this point makes it impossible to support implementation of the service in the form proposed and within the timeframes proposed.

Both funders and providers will require greater surety on:

- a) criteria for patient selection;
- b) likely volumes;
- c) key inputs and how they will be funded – as a baseline it is important to define what service is expected within the current dispensing fee; this is not well-defined at present;

d) modelling which indicates that the volumes anticipated will be able to be funded from money released from weekly close control and other savings within the dispensing pool.

The suite of services included is both comprehensive and intensive as mentioned previously, more in line with what is expected from a MUR service. This is not consistent with the intention that the services be a) within the capability of all community pharmacists without further training b) within the likely funding that will be available from the dispensing pool to fund these services. This is particularly pertinent in South Auckland which currently has relatively low rates of close control by national standards. On the other hand it has a very large population of patients with long term conditions fitting the broad criteria for the LTC service suite as currently proposed. CMDHB perceives significant risks in controlling its pharms budget unless it is able to control the numbers eligible for these services.

The proposals are simply not feasible in their current form because they pose an unacceptable risk for both funders and providers.

The changes proposed for patients with LTCs are too significant and too complex to enable good planning and implementation within the timeframes. In CMDHB the major issue with Close Control is the use of weekly CC to support compliance packaging. It is suggested that the Steering Group consider how to address this issue as a do-able step in the timeframes while committing to implementation of a more comprehensive but well planned, well modelled financially, and thus well justified patient-centered service for LTCs.

**NDHB view:**

Need to define what the barriers are for preventing individuals from complying, then a range of activities to be developed to support that client in achieving compliance.

Perhaps a 2-tiered approach. The first step - an SA application for patients identified as having problems which might be affecting their ability to manage their medicines. This SA application could be initiated by the pharmacist but referred to the GP for completion. This application would be only for a "medicines screening and review" to be performed by the pharmacist to identify the barriers (including social problems, cultural beliefs, etc) to medication adherence. The pharmacist would prepare a further SA application including recommendations for further services (if defined necessary) which would be reviewed, preferably in an MDT environment wherever possible, with the general practice staff and after agreement the SA application would be sent for approval of further service delivery or closing of the original SA if further services are deemed unnecessary. It may also include referral for a higher level service such as MUR or MTA.

Pharmacists may need support from cultural advisors/representatives to 'open doors' to some patient populations to be able to optimise the value of the "medicines screening and review".

7 b) What services you would add or delete?

Add gout to conditions characteristics. Often the first clinical presentation of metabolic syndrome which heralds diabetes, CVD etc. Management of patients with gout by pharmacists will include intensive monitoring of the patient on allopurinol for 3/12.

Available services will all be subject to funding and more detail is required such as service specs, costings and capped volumes etc.

It is possible to define four key value-added services that community pharmacy is well placed to provide, namely:

- Medicines reconciliation and a yellow card;
- Alignment of medicines;
- Compliance packaging;
- Adherence monitoring ( dispensing on time, medicines collects);
- Liaison with the patient's medical home.

We consider these to be the essential components for adherence, within the capacity and capability of any community pharmacy and relatively simple to perform within a well organized and not overcomplicated process.

**Question 8**

8 a) Should Proposals 1 and 2 be implemented as a single package or should there be a transition period?

Proposals 1 and 2 are inter-connected as removal of the access to close control as stated in proposal one is dependent on access introduced in proposal 2.

There needs to be a fully scoped implementation plan that considers risk and mitigation strategies for both clinical and financial matters.

A single package very important for CMDHB's high disparity community. A significant proportion of high disparity patients with poor English language skills rely on compliance packaging currently funded through weekly close control. However the section of close control rules relating to institutions could proceed and having regard to the tight time frames, may be

easier to implement in the first instance.

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?

Need to consider and confirm adequacy of service coverage for patients.

One would question whether the proposed changes are transformational, and whether we are setting a course for future community pharmacy sustainability, if a major consideration is to not unduly affect pharmacy, given that funders cannot continue to sustain 8% plus growth rates.

8 c) Should Proposals 1 and 2 be implemented nationally, regionally or in pilot sites?  
Please provide reasons for your views?

It feels as if currently the proposal is not detailed or defined enough to enable a decision on implementation with the information available. It is too complex, there is not enough time and involves changes to sector services and other system requirements.

For these reasons, we suggest piloting these proposals in the first instance to test the criteria and related systems; at a minimum this should be introduced at a Regional level (if not National).

**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.**

**Question 9**

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

As it is DHBs who carry the financial burden of more frequent dispensing rules we would welcome the removal of monthly dispensing for new meds unless the need for this rule can be more clearly justified.

**20 DHB Consultation Proposals**

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

**Question 10**

10 a) Do you have any comments to inform the key components and expectations for this service?

The service components as described in a patient journey are reliant on systems that are not yet in place such as a shared care record, the journey stipulate accessing specific services which have been previously stated as optional services the prescriber selects, it is highly aspirational. The pathway includes aspects of a patient's journey which is out of the control of community pharmacy, such as medicines reconciliation discharge processes from hospitals and auxiliary providers. There is also an issue of drugs that are dispensed for a patient to take home with them that would be done from the hospital retail pharmacy (most likely) as opposed to the patient's nominated pharmacy and issues of information sharing would arise. The patient seeing a pharmacist at a specified time to go through a medicines reconciliation would also seem to be a similar system to a medicines utilisation review - Is this offering a dumbed down (i.e. no accreditation) MUR service?

**CMDHB view:**

The service proposed is a broad one that includes responsibilities for both hospitals/primary care providers and community pharmacy. It is now picking up a mantle that is already in process through other strands of work within individual DHBs and the BSMC business cases. It is questionable whether this is an appropriate role for the national pharmacy steering group. The proposals should focus on the service to be provided by and within the control and accountability of community pharmacy.

**NDHB view: please excuse formatting issues**

The proposal is based on the assumption that the process will be initiated by GPs. It is more likely that it is the pharmacist who identifies barriers to patient adherence and there may be benefits to pharmacists initiating the process (by formal referral to or initiation of an SA application for the GP).

As suggested before, perhaps a 2-tiered approach. The first step - an SA application for patients identified as having problems which might be affecting their ability to manage their medicines. This SA application could be initiated by the pharmacist but referred to the GP for completion. This application would be only for a “medicines screening and review” to be performed by the pharmacist to identify the barriers (including social problems, cultural beliefs, etc) to medication adherence, possibly using a simple assessment tool, e.g. like CMDHB RAG used in the ACS/VHIU unit. Based on these findings, the pharmacist would prepare a further SA application including recommendations for further services (if defined necessary) which would be reviewed, preferably in an MDT environment wherever possible, with the general practice staff and, after agreement, the SA application would be sent for approval of further service delivery or closing of the original SA if further services are deemed unnecessary. It may also include referral for a higher level service such as MUR or MTA.

Pharmacists may need support from cultural advisors/representatives to ‘open doors’ to some patient populations to be able to optimise the value of the “medicines screening and review”

10 b) Which do you think are the most essential services and how could funding be targeted to them in an auditable way?

Many of the service components listed are aspirational and are dependent on longer timeframes than this proposals allows e.g. e-prescribing. Given the SA criteria caters for people with higher needs, then the pharmacy services which would wrap around this would need to be over and above the current level of supervision. Service component number 7

describes a practice which would seem to align with a medicines utilisation review service. Metro Auckland DHBs are exploring a regional MUR initiative but would welcome a national approach to this if a similar type of service specification was used to ensure quality delivery of service which is auditable. However this would need to be national enhanced service variation that had to applied and accredited. This may mean that by default business is driven to these selected pharmacists.

There is a need to make sure this does not incentivise changes in service delivery that result in poor patient outcomes through reduced services.

**CMDHB view:**

Failure to take medicines occurs for many different reasons. A systems approach is required that involves the patients GP, the treatment plan, access for the patient to professional services, family and social support, service integration particularly following a hospital admission, IT linkages . For high disparity patients all facets of this system are needed to support the patient. The expectation that the proposed service will address the system issues is unrealistic.

However, it is possible to define four key value-added services that community pharmacy is well placed to provide, within a system, namely:

- Medicines reconciliation and a yellow card;
- Alignment of medicines;
- Compliance packaging;
- Adherence monitoring ( dispensing on time, medicines collects);
- Liaison with the patient's medical home.

CMDHB considers these to be the essential components for adherence, within the capacity and capability of any community pharmacy and relatively simple to perform within a well organized and not overcomplicated process. The goal is to incentivise the pharmacist to focus on the patient, their medicines and therapeutic outcomes. In CMDHB's view this is best funded in the medium term via a patient service fee as the current structure of the sector is not yet ready for a capitated system of payment and the experience of capitating general practice has proven that this alone does not improve care and increases costs significantly.

There is no easy or efficient way to audit service provision. It is costly and difficult. The history of health service delivery shows that audit cannot be relied upon to control appropriate service utilization and costs. Developing measurable outcomes is in itself problematic. It is much better to focus on supporting and encouraging providers who do the right thing.

It is not difficult for DHBs who communicate well with their providers to form a general view on which providers are delivering quality. However DHBs appear to have no means of defining quality service delivery let alone differentiating and rewarding providers who are attempting to deliver quality services.

This proposal will hopefully start the shift to provide rewards for a patient focus, However other changes to the manner in which DHBs contract for services will be needed to reward those providers who deliver quality of service from those who do not. Audit is seldom the answer.

**NDHB view:**

We suggest a 'medicine compliance model' rather than 'medicine use review'.

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?

These services need to be piloted because there is no financial analysis available within the documentation that proposes there would be sufficient funding for all those patients in the identifiable group in the first instance. The SA process would restrict to only those patients who are within the identified patient group, but the SA approval method is unclear as to how it may work within a limited financial environment. To ensure that SA's are being granted appropriately they need to be audited on a regular basis including random patient audit and follow up.

If the financial modelling shows that there could be potentially greater need than funding available a capped volume of SAs could work through a process of either capping numbers within nominated pharmacies, capping length of time for SA, or the number of times SA can be re-applied for.

There should be continual review of the patient group (e.g. 6-monthly) to ensure appropriate allocation, together with outcomes data. KPIs need to be developed.

**Question 11**

11 a) Please comment on the funding options put forward

It is difficult to know how to respond to this question without a full knowledge of how much is going to be saved through the suggested mechanisms to know how much would be made available for the other options. Without knowing how much the options being proposed will cost to administer, we have no definitive view on this, but need to ensure that the funding model incentivises the correct behaviours.

11 b) Identify whether you have a preferred mechanism(s), and the reasons for that preference

With the limited information available it is difficult to know which option is the most feasible or the administrative burden involved in it. A graduated service fee per patient attached to the SA process would seem a sensible and auditable solution .However what happens to the funding if a patient moves pharmacy, what motivation is there for the pharmacists to deliver the services?

11c) Do you have any suggestions for alternative funding mechanisms?

Enhanced dispensing fees would ensure funding is attached to a 'live' patient, and funding is transferred at time of service.

On page 18 of the document is a list of potential services that pharmacies may be requested to provide. Consideration could be given to allocating funding based on the number of selected services required for the individual patient. As an example, the initial SA application may be only for a medicines review, with additional services being applied for after consultation with the general practice team and as dictated by individual need.

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?

This system would seem to discourage pharmacists from following up on the later dispensings as these would attract a lower fee. It does not resolve the issue of uncollected meds or medicine adherence. It does not include high cost medicines which is currently a stocking issue with pharmacists. Administratively and dispensing-wise cumbersome.

A tiered fee reflects the initial high level of input which we are seeking from pharmacists, but as highlighted above does not motivate subsequent interaction.

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

**Question 12**

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

Consistency in approach would be a benefit but there would still be limited providers willing to service ARRC and after hours requirements. The service provision depends on the funding which supports it as it is labour intensive to be part of multiple multi-disciplinary teams if a number of facilities are serviced.

It is not entirely clear (Service Outline 5) whether payment will be made for monthly dispensing irrespective of a higher dispensing frequency. If the dispensing fee paid is based on the dispensing frequency there is significant risk that compliance packaging will continue to be funded by indiscriminate use of more frequent dispensing.

The ARRC agreement will need to be varied to make explicit the requirements relating to including pharmacists as part of a MDT and their tasks.

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

There needs to be very clear and precise service specifications for the inputs and outputs/outcomes, and these need to be fully auditable.

**Question 13**

13 a) Please provide comments about the Pharmacy Agreement options

It would seem contradictory that a remote location of supplier is supported while the main focus is on the service delivery and inclusion as part of the multi disciplinary team.

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

We would support the reflection of the pharmacy contract service expectations in the other relevant party documents such as ARRC, PHO and/or alliance agreements, to avoid the possibility of creating multiple funding streams.

**Question 14**

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

A service fee per patient would seem a reasonable model however this may require administrative burden of knowing the occupancy of each facility; need to ensure these patients are not also eligible for funding under the long-term conditions provisions.

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

No.

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

**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

The proposal does not set out any new processes than those that are currently in place. The document acknowledges that it was difficult to engage with this sector and it appears that many in the sector were not aware of this consultation process. It would be beneficial to request, through DHBs, that this occur at a local level to identify and therefore address any issues that this sector may have with pharmacy, because it is such an important part of the service they run.

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

It may be that this group of patients have similar requirements to the LTC category, rather than ARRC, as they have a greater degree of autonomy available to them within their residences and should be supported to 'live an ordinary life' and opportunities to participate in everyday life wherever possible. The more people in community residences that can be supported in managing their medications, the greater the opportunity for them to live independently at some stage.

**Question 16**

16 a) Please provide comments about the Pharmacy Agreement options

As stated previously in the ARRC section, it seems contradictory to require that pharmacists interact more with their patients and provide patient-centered care, while also stating that contracting options should remain flexible and enable providers (such as wholesalers) to sub-contract the supply functions. It is important for community supported residents to be able to have a choice of pharmacist and primary care practitioners and for both the patient and their support workers to be educated around their medications as part of the better, sooner, more convenient' primary care policy direction. Auckland DHBs consider continued linkage of dispensing, advice and pharmacy/patient relationship will result in optimal therapeutic outcomes.

It would be beneficial that any requirements or guidelines that may be drafted around providing pharmaceutical services for those in community residential support services should also be reflected in the agreement between DHBs and the CRSS so all parties are aware of the contracted expectations.

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

This would need to be discussed with affected parties as there may be quite substantial difference between how providers operate. Some may have preferred GP and pharmacist providers much the same as ARRC; others may allow the clients to maintain those primary care relationships they already have. It would need to be managed on an individual provider, or at least grouped provider basis.

**Question 17**

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

Since Auckland DHBs wish to support patient autonomy and encourage them to live a normal life, our preference would be for these patients to be considered within the LTC criteria. Therefore it would be appropriate that these services are accessed through a Special Authority model.

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

Depending on the nature of the establishment it may be possible that these services are funded out of the mental health funding pool.

Thank you for taking the time to make a submission. Your contribution is important and will be fully considered.