20 District Health Boards

Community Pharmacy Service Options for People in Age-Related Residential Care

Discussion Document

October 2010

Introduction

The *Community Pharmacy Service Options for People in Age Related Residential Care Project* [the Project] is one of five strategic projects that will inform the development of the 20 DHBs' Pharmacy Services Agreement 2011 with around 900 community pharmacies across New Zealand. The Project is led by the 20 DHBs, mandated by the multi-party Steering Group and conducted within the principles adopted by the Steering Group:

a. maximising value to patients, with emphasis on improving safety and self management
b. open transparent processes, with decision making processes clear
c. stakeholder involvement
d. explicitly valuing pharmacists' clinical skills and contribution to primary care delivery
e. the need for prioritised, affordable development of community pharmacy services within DHB funding parameters, with risks managed.

People in age-related residential care facilities are vulnerable and require special protection to ensure their needs are met. They are generally frail, elderly and may not have family or community advocates.

We want to understand more about how, and how well, pharmacy services currently support best health and wellbeing outcomes for residents, and whether a new or revised service model could operate more effectively and efficiently.

The Project will go through three stages between October 2010 and May 2011. The first two stages provide opportunities to hear the views of people living in age-related residential care as well as key members of the multidisciplinary team: practitioners, pharmacists and facility staff and national representative or advocacy organisations.

i. **Discussion document:** feedback on pharmacy service issues and options for people in age-related residential care, funding arrangements and incentives.

ii. **Formal consultation proposal:** released after consideration of the discussion document feedback. A preferred service model will be finalised following the consultation process.

iii. **Pharmacy Agreement 2011 consultation:** DHBs will consult pharmacy agents on service directions for the Agreement from 1 September 2011 and develop an Agreement package.

Feedback

Feedback on this discussion document is due by:

30 November 2010

You can provide your feedback in a number of ways. Our preference is for you to use the on-line survey tool, SurveyMonkey, as this enables fast and accurate analysis.

On-line via SurveyMonkey

The link to access the survey is:

https://www.surveymonkey.com/s/SV28M8P

Please type the link into your brower.

Email

PharmacyARRC@dhbnz.org.nz

Paper

Print off the survey pages from this document and complete, using additional paper as required, and send to:

PO Box 5535

Wellington

Please note: this is a public process.

This means that your feedback will be made available for others to read if they ask. You can, however, answer anonymously or you can ask us not to make it available (although you will need to state your reason).

Community Pharmacy Services for People in Age-Related Residential Care

The Process

In broad terms, community pharmacy services are provided to people in age-related residential care as set out below. There may be some variations in the service model:

- A resident will see a practitioner at least every three months if their condition is stable, and urgently or more often where that is required.
- The practitioner who services the facility, or is the individual resident's preferred practitioner, will chart the medications the resident requires to improve their health and wellbeing.
- At the point of admission to the facility, the pharmacist may conduct a reconciliation process between general practice and hospital prescribing that establishes what medications the patient is receiving.
- The practitioner reviews the medication for each subsidised resident in residential care at least every three months. The same arrangements may also apply for residents who fund their own care.
- The medication is charted in the facility's individual chart for that resident, and this forms part of the resident's care plan.
- The chart is provided to the community pharmacy who services the facility.
- The community pharmacist checks the chart for dosages, and interactions, and generates a script based on the chart and this is sent to the practitioner to sign. The pharmacist is legally able to annotate the script items as close control (ie, dispensed monthly rather than three monthly).
- The community pharmacist packs the medications and delivers them monthly to the facility, or more frequently if medications change during the period.
- The facility pays the co-payment and any part charges for the dispensed medications for publicly funded residents (and is funded for this via the DHB Age Related Residential Care Agreement). Residents funding their own care pay these charges themselves.

- The pharmacist submits an electronic claim which records all dispensings made against the pharmacy-generated script, backed up by the hardcopy script received from the practitioner.
- The community pharmacist may also provide a Bulk Supply Order to a licensed hospital (which some Age Residential Care facilities are).
- The community pharmacist may provide education, clinical advice and information to the facility staff to assist their management of medications.
- The community pharmacist may or may not engage directly with the individual resident.
- The community pharmacist will engage as necessary with the practitioner regarding the treatment regime, review of prescribing, synchronisation of scripts and other matters as required.
- The community pharmacist will also engage with hospital practitioners about medications that have been prescribed when the resident was in hospital.

The Key Stakeholders

This section describes the key stakeholders' roles and responsibilities in relation to pharmacy services to people in age-related residential care.

Residents

About 32,400 people live in age-related residential care at any one time, about 0.7% of the NZ population, with approximately 42,000 people in care during a year. Residents are publicly[1] or privately funded, and may be in rest home, hospital or dementia level beds, depending on their care needs. Most are over 75 years, but about 800 people younger than 65 years are funded by Disability Support Services to live in these facilities. All residents are entitled to receive publicly funded pharmacy services and medications, with co-payments and user part charges paid directly by privately funded residents, or by the facility for publicly funded residents.

People in residential care are often frail, and have multiple health and disability issues; they are admitted to hospital more frequently than other groups. They may be enrolled with their own general practice, or use the practitioner contracted by their facility. They are likely to access pharmacy

1 People must be assessed by DHB-contracted Needs Assessment and Coordination (NASC) agencies as requiring long-term residential care before their care can be publicly funded.

services provided by the pharmacy their facility has an arrangement with. The facility nurse manager or Registered Nurse may act as the primary point of engagement, and the resident may have little or no interaction with the pharmacist. Residents' prescription forms are usually filled monthly or more often if medications change. Administration of medication is usually overseen or given by facility staff – both clinical and non-clinical.

Residents are significant users of pharmacy services: nationally approximately 6% of all community pharmacy dispensed prescription medication items and dispensing fees are generated by people in aged residential care. On average, the total pharmaceutical cost for people in age-related residential care is $1,467 per occupied bed, made up of $860 for drug costs and $610 for dispensing fees and pharmacy mark ups. Analysis shows an average of 24.9 dispensing events per person per year compared to 9.5 events per similarly aged person per year in the community; 81% of residents are on six or more medications (twice as many as the community cohort), with higher utilisation of special foods than in the community.

Residents have high health needs so their high usage of medications is not unexpected. It does, however, reinforce the importance of optimal use of medications from the perspectives of service, quality, health outcomes and expenditure.

Practitioners/Prescribers

Primary, community and secondary practitioners include general practitioners, nurse practitioners and hospital doctors. They:

- consult with residents at least three monthly or more urgently if required
- make prescribing decisions about which items are to be dispensed and how they are to be dispensed
- chart medications and write prescription forms
- contribute to, and support, multidisciplinary teams through working relationships with facility management and nursing staff, community pharmacists and hospital practitioners.

Residential Care Facilities

Facilities are responsible for ensuring residents have appropriate access to practitioners and pharmacy services. They may enter specific service arrangements for the supply of these services to their residents.

Facility nursing staff liaise with practitioners to ensure assessment, treatment, diagnosis and prescribing occur and are written up in the resident's Care Plan.

The Pharmaceutical Schedule allows residents in aged care facilities to receive monthly supplies of medication. Facilities may also request that pharmacies provide compliance packaging for

storage and safety reasons and to assist staff and residents. Bulk Supply Orders may also be accessed if the facility is a licensed hospital.

Community Pharmacists

The community pharmacist receives the resident's chart and/or prescription form, checks it for appropriateness, dosage and interactions, packs the pharmaceuticals and delivers them to the facility for each named resident. Some pharmacies may use robots to pack medications in compliance packs. The community pharmacist may also provide a Bulk Supply Order to a licensed hospital.

The community pharmacist may provide clinical education, advice and information to the facility staff to assist their management of medications. The community pharmacist may or may not engage directly with the individual resident.

The community pharmacist will also engage as necessary with community and hospital practitioner(s) regarding the treatment regime, medication reviews, synchronisation of scripts and other matters as required.

Service Issues and Questions

To understand more about how, and how well, pharmacy services currently support best health and wellbeing outcomes for residents, and whether a new or revised service model could operate more effectively and efficiently, we ask for your views on the following service issues and questions, and any other related issues.

Satisfaction with Community Pharmacy Services Delivered to Age Care Residents

We want to know how satisfied residents (and their families/advocates), practitioners, pharmacists and facilities are with pharmacy and medication management services as they are currently.

1. Which of the following best describes you? (Please tick as appropriate)

Resident in an age care facility	
Family member of a resident in an age care facility	
General practitioner	
Secondary care practitioner	
Community Pharmacist	
Age care facility owner	
Age care facility manager	
Age care facility registered nurse	
Representative of a professional or provider or advocacy group, organisation, agency or company – please identify:	
Other – please specify	

2. Identify the pharmacy and medication management services **provided to or for** residents in your current experience: Please tick all that apply.

	Service	Provided by Practitioner (GP, Hospital Doctor)	Provided by Community Pharmacist	Provided by Facility Staff
a.	Prescribed medications			
b.	Over the counter medications			
c.	Bulk Supply Order (if licensed hospital)			
d.	Advice & counselling			
e.	Medication reviews			
f.	Information pamphlets			
g.	Compliance packaging			
h.	Daily deliveries			
i.	24 hour on call service			
j.	Staff training			
k.	Other (please specify)			

3. Thinking about the pharmacy services, what would you say is working well, and why it is working well?

4. What would you say is not working as well, and why do you think this is?

5. Do you have any suggestions about how the services could be improved? Please add reasons and priorities.

6. Please rate how satisfied you are overall with the pharmacy and medication management services currently provided:

Very dissatisfied		Satisfied		Very Satisfied
1	2	3	4	5

Practitioner ⇔ Facility ⇔ Community Pharmacy working as a multidisciplinary team

We are interested in the factors that support improved resident health outcomes and that either improve or limit the quality of multidisciplinary teamwork and interaction between practitioners, facilities and community pharmacy.

7. Are prescribing decisions for people in residential care similar, or different, to prescribing decisions for people in the community?

	Reasons
Similar	
Different	

8. What factors do you think contribute most to effective working relationships between prescribers, pharmacies and facilities? *Please include all factors you think are relevant*

	Factor	**Reason**
a.		
b.		

9. What factors inhibit &/or limit optimal working relationships? *Please include all factors you think are relevant*

	Factor	Reason
a.		
b.		

10. How could working relationships be improved to benefit residents most?

Improving the Design of the Pharmacy Service Model

Pharmacy services include dispensing and supply of medications, provision of advice and counselling, maintenance of patient records, compliance with legislative requirements, and maintenance of linkages with related professional services. Services are currently paid for on a fee-for-service basis, with each prescription item attracting a fee of $5.30 plus 4% mark up.

We want to understand whether the current service, funding and contracting design is the most effective way to provide services to the people in age residential care who have high health needs, are on multiple medications, and may have frequent hospital admissions. We are interested in your feedback on design options that might be safer, more effective in using pharmacists' clinical skills and provide better value within the funding available.

11. How important are the following pharmacy service inputs, and why?

Input	Importance (tick as appropriate)			Reasons
	Not at all important	Important	Very important	
Seven day a week service availability				
Five day a week service availability				
Five day a week service availability with after hours provision				
Synchronisation of prescribing and packaging cycles				
Compliance packaging				
Bulk Supply Orders				
Monthly Close Control				
Specified response times for scripts to be filled and therapy commenced				
Information and education to facility staff				
Clinical capacity of facility staff				
Individual residents' access to Pharmacists				
Facility access to Pharmacists' clinical skills, advice & counselling				
Relationship with practitioner (e.g. GP)				
Relationships with hospital services				
Pharmacy management of unused or returned medications				
Any other inputs that should be considered & assessed?				

12. What do you think are the essential elements of any new pharmacy and medication management service model to residents? *Please include all factors you think are relevant*

13. What changes to pharmacy services would need to be made to implement the new service model that you are suggesting? *Please include all factors you think are relevant*

14. How would residents' health outcomes improve, and hospital admissions decrease, as a result of the changes?

15. What funding option do you think would most support the new service model you are suggesting?

Funding option	Reason
Fee per script item	
Fee per patient	
Fee per bed	
Fee per facility	
Other?	

Additional Perspectives

15. What other issues, questions or perspectives need to be considered in the design of pharmacy services to residents?

Thank you for responding to this discussion document.

This is an open process. This means that we must make your feedback available to the public unless you ask us not to. If you want to answer anonymously please do not give us your name or contact details. If you do not want us to make your response publicly available please let us know and tell us why.

In accordance with the Privacy Act, if you provide the information in this section, the information will be used by the 20 DHBs to consider responses to this discussion document. Please note that DHBs are required by law to ensure that all responses received (including the names of the respondent people or groups) are available to the public, unless there is grounds for withholding them under the Government Official Information and Meetings Act 1987. If you object to your submission being publicly available please let us know, stating the reasons.

Please let us know how you feel about your feedback being made publicly available by crossing out one of the following:

I do not object to my submission being made publicly available

I object to my submission being made publicly available

Please provide your contact details if you wish to:

(Please note you do not have to provide these details. However, if you want us to advise you when the feedback summary and consultation proposal are available you will need to provide your email address).

Thank you for your time and your feedback. We will be looking at all the comments and collating these into a report. The results will be available at www.dhbnz.org.nz in December 2010 and if you have provided your email address we will email you the link to the report when it is available.

Dr Sharon Kletchko, Lead GM Planning & Funding, Pharmacy

Glossary of Terms

Term	Description
Age-Related Residential Care Facilities	ARRC facilities offer a range of beds as part of the services purchased either by DHBs or directly by private paying residents. Some also offer residential village services including Licence to Occupy arrangements. They must meet the NZ Health & Disability Service (Safety) Act 2001 requirements. Facilities must comply with the Medicines Act 1981; have and implement policies relating to safe medications management and administration, medications storage in accordance with the *Safe Management of Medicines, A Guide for Managers of Old People's Homes and Residential Care Facilities, September 1997*. They must also facilitate attendance by a GP or other health practitioner within prescribed intervals and maintain clinical records, a medicines chart for each resident and a Care Plan. Facilities pay the government prescription charge, any manufacturer's surcharge and any package and delivery charge made by the pharmacist for any subsidised resident. Residents may be required to pay the cost of any pharmaceutical over and above the charges stated above.
Age-Related Residential Care Agreement	District Health Boards purchase three main bed types at a bed day rate for eligible people assessed as requiring residential care in ARRC facilities: • Rest home • Hospital • Dementia. People who have not been assessed as requiring long-term residential care pay privately; others are fully or partially paid for by DHBs. Some DHBs also purchase psychogeriatric beds. The ARRC agreement specifies service and quality requirements.
Base Pharmacy Services Fee	A base dispensing fee of $5.30 payable for each item on a prescription form (script). Pharmacists also receive a procurement and stockholding margin (usually 4 percent).
Bulk Supply Order	Drugs, including some controlled drugs, that can be provided in lots of up to one month supply, to licensed hospitals
Close Control	The Pharmaceutical Schedule (the Schedule) defines the conditions under which a community pharmaceutical may be dispensed under close control, that is, more frequently than the usual expectation of three monthly dispensing. The Schedule permits pharmaceuticals to residential care facilities, and to patients with an intellectual disability, for example, to be dispensed via monthly close control. Close control is designed to ensure that the patient is monitored with sufficient regularity to prevent ineffective therapy or adverse outcomes from medicines' use. This may be appropriate where new medicines are being trialled or introduced, particularly where the medicine has a low therapeutic index or where dosages are likely to change, or where the patient's condition is not yet stable. The primary consideration is the capability of the patient to safely manage their medication, however the nature of the medication being prescribed may influence this decision
Community Pharmacy Services Agreement	The contractual arrangements between the ~900 community pharmacies in NZ and their local District Health Board. DHBs expect the base pharmacy services (dispensing) fee expenditure for all these Agreements to total $365 million (GST excl) in 2010/11
Community Pharmaceutical Budget	The annual budget for community pharmaceuticals that PHARMAC manages on behalf of DHBs, which is agreed with the Minister of Health. The budget for 2010/11 is $710 million.

Term	Description
Community Pharmacist	A person registered as a pharmacist with the Pharmacy Council and who holds a current annual practising certificate under the HPCA Act, and operates in the community
Dispensing	The process of a Pharmacist providing a person or their caregiver, or a Prescriber, with a Prescription Item pursuant to a Prescription Form, order or NRT Exchange Card. It includes all the steps that occur from receipt of the Prescription Form, order or NRT Exchange Card at the Pharmacy to the Prescription Item being collected by, or delivered to, the Service User or the Service User's caregiver or Prescriber, and includes information and advice that a pharmacist may provide
IDCC&R	Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003
Medication management services	A clinical pharmacist will typically provide medication therapy management services through review of a list of medications the patient provides. The things the pharmacist will look at include drug interactions, duplications of drugs from the same family, doses, routes of administration, and the formulation the patient is using. This review will also include evaluating medication habits to see where patient benefits may be optimised.
MHCATT	Mental Health Compulsory Assessment and Treatment Act1992
Patient Copayment	The amount the government decides that a patient is required to pay towards their pharmaceuticals. Currently this is $3 per script for most people. In addition, patients may be required to pay a part-charge if the pharmaceutical is not fully subsidised
Pharmacy Services Steering Group	Comprises DHB regional representatives, Pharmacy agents, Ministry of Health, Sector Services, PHARMAC, general practice.
Pharmaceutical Schedule	A list of the approximately 2000 prescription medicines and therapeutic products subsidised by the Government (via the Community Pharmaceutical Budget agreed annually with the Minister of Health by DHBs and PHARMAC).
Prescriber/Practitioner	A health professional registered under the Health Practitioners Competency Assurance Act who is legally permitted to prescribe all or some pharmaceuticals to a patient, for example General Practitioner, Hospital Specialist, Nurse Practitioner, Dietician
Prescription Form	A form completed and signed by a Practitioner in accordance with the Medicines Regulations 1984, which specifies the Pharmaceuticals prescribed for a named person. The community pharmacist must receive an original form in order to claim payment for the items on the form
Special Foods	Products listed in the Pharmaceutical Schedule that are fully or partially subsidised, including oral supplements, complete diets, food thickeners, gluten free foods, infant formulae
Stat Dispensing	Scripts for most pharmaceuticals are written for three months and dispensed in a three-month lot
Synchronisation	A pharmacy based process that aligns the provision of medications to a single date for the patient's convenience