New service model for community pharmacy

Introduction

There are significant and far reaching changes included in the new Pharmacy Services Agreement from 1 July 2012. This follows on from extensive engagement with community pharmacy to consider options for change. The key change is a patient-centred model of care designed to enable pharmacists to better tailor services to patients, particularly to patients with multiple co-morbidities and on many medications, and strengthening communication between members of the patient’s multi-disciplinary team in the plans by for managing the patient’s medicines.

Key strategic drivers include:

- the desire to give pharmacists incentives to better use their clinical medicines management expertise and work at the top of their scope of practice;
- re-orienting community pharmacy services around the patient and facilitating increased integration with prescribers across all settings of care, but in particular with the general practice;
- the need to ensure that the funding for community pharmacy is linked to patient outcomes; and
- that the funding model is sustainable.

The 20 DHBs first consulted with community pharmacy providers on the development of a new service and funding model in November 2010, and another consultation was undertaken in March 2011. A pharmacy led workshop was held in September 2011 to inform and agree on a new patient-centred service, and this was followed by a number of meetings with community pharmacists, DHBs and other stakeholders to refine the service model concept and transition arrangements. The five workstreams developed following this workshop were:

- Services definitions
- Assessment criteria and referral process.
- Indicators for quality and quantity
- Transition implementation plan
- System for reimbursement/costing of service

DHBs, supported by PHARMAC, then developed the proposed funding arrangements to ensure the incentives to community pharmacies were aligned with patient services and were sustainable for DHBs.

A final stage of engagement occurred between 26 March and 27 April 2012 when each DHB undertook consultation with community pharmacy providers on the proposed new Community Pharmacy Services model.
**Background**

In the current model pharmacies are paid on volumes of medicines dispensed, and the resulting expenditure growth in pharmacy dispensing costs is unsustainable. The linking of funding to volumes has little relationship with patient outcomes.

In 2009/10 out of total dispensing fees of $320M, $82M was spent on Close Control. Of the $82M spent on Close Control, $46M was spent on weekly Close Control.

The **Close Control** Pharmaceutical Schedule Rule has provided a mechanism which has allowed pharmacies to dispense more frequently to some patients, and it is believed there is an element of over-servicing in this funding. Aside from trialing new medicines, weekly dispensing should be an exception, rather than a rule, for example for people with safety issues.

The **new service model** introduces a new service – **the Long Term Conditions Service** – that will target those patients who need help managing their medicines, and therefore contribute to better patient outcomes. It is expected that many patients who are receiving Close Control dispensing will be registered in the LTC Service in the new service model.

**Three new categories for services to patients according to needs**

The new service model for community pharmacy introduces three patient categories:

- Core Services;
- Long Term Conditions (LTC) Services; and
- Specific Services

The majority of patients who currently receive episodic care under the existing Agreement and those with chronic conditions who are well managed on their medication shouldn’t notice any change in their interactions with their pharmacist.

**The new LTC Service is for those patients with the highest needs**

The new Long Term Conditions (LTC) Service is aimed at the group of patients that prescribers believe need the most support from pharmacists. Not all patients with a LTC will be eligible. For example, if a diabetic is well controlled and takes their medicine as prescribed, this person doesn’t need receive the extra care in the LTC Service.

Patients who are currently high users of pharmacy services, (e.g. patients on weekly or monthly Close Control) will be assessed by their pharmacist, and if eligible will be invited to register with the pharmacy for the new LTC Service. These patients will have a Medicines Management Plan developed by the pharmacist. A Medicines Management Plan won’t be time limited – it will allow the pharmacist to work with the patient to address each issue over a period of time. Some solutions will be quick (e.g. using compliance packaging), but others will take much longer (e.g. enhancing health literacy).

As part of the assessment it is expected that the pharmacist will seek information from relevant members of the patient’s multi-disciplinary team and make the Medicines Management Plan available to them.

The services that a pharmacist could provide to patients are likely to include: checking that medicines prescribed by different prescribers are not acting against each other; synchronising a patient’s repeat prescriptions to avoid unnecessary trips to the pharmacy or GP; reminding the patient how to take the medicine; and referring the patient to other services, such as the Needs Assessment and Service Coordination (NASC) service.
General Practice has been involved in the development of the new service model

Community pharmacists, DHBs, pharmacy sector agents, PHARMAC and the wider health sector have developed the new service model over the past two years. A steering group met every six weeks until November 2011 and included a representative of the RNZCGP.

Meetings have been held with the GP Leaders Forum, the Community Pharmacy Leaders Group, RNZCGP, NZMA, GPNZ, and the Pharmaceutical Society to seek feedback on the proposed changes and they are all very supportive of the approach.

New service model aligns to health priorities

The new model aligns with the Government’s health priorities around integrating primary care and improving management of LTCs through:

- Moving interventions upstream with earlier implementation of evidence-informed actions.

- Bringing health services closer to home – the suite of LTC Services are community-based.

- Improving the health and independence of older people – managing medicines for older LTC Services patients would mean better health outcomes and help them to continue living independently.

- Strengthening the health workforce – the proposed model encourages and rewards pharmacies for working at the top of their scope of practice; and would foster the multi disciplinary team approach.

- Improving value for money – the new service model reduces the ongoing growth in dispensing fees while focusing on health gains for the most ‘at risk’ patients.

Peer review, education and incentive payment used to drive quality

The Community Pharmacy Services Operational Group has been set up to oversee the delivery of the new community pharmacist services model and a strong performance and audit strategy is being developed. Peer review, education, and best practice standards are going to be important parts of that strategy, and audit would be used only when there was a performance issue and standards were not being met.

A new Quality Framework will see up to five percent of the total funding set aside as a quality incentive payment against defined criteria.

No change to Age-Related Residential Care (ARRC) service

There will be no immediate change to the Age-Related Residential Care (ARRC) service, but DHBs are considering a separate service for this group of patients from 2013/14.

MUR and MAT are not included in the new Community Pharmacy Agreement

The new Pharmacy Services Agreement covers services that can be provided within the current scope of community pharmacy services, at Level A of the Pharmacy Council Competency Framework. Medicines Use Review and Medicines Therapy Assessment are not part of the new Agreement. The Medicines Management Plan is not a Medicines Use Review.
**Changes to Close Control**

From 1 July 2012 PHARMAC is removing the Close Control Rule and replacing it with the “Dispensing Frequency” Rule. The key change is the Close Control Rule relating to patients who are “intellectually impaired, frail, infirm or unable to manage medicines”. This clause is being removed from the new rule.

In the coming months pharmacists will assess these patients for eligibility in the new LTC Service, or transition them safely into the Core Pharmacy Service. Patients should remain on the same dispensing frequency until they are assessed for eligibility in the LTC Service.

In practice, for prescribers this means that annotating a prescription with ‘Close Control’ is no longer required and the pharmacist dispensing the medication is able to determine the dispensing frequency for LTC Service patients.

For non-LTC Service patients dispensing shouldn’t be more often than monthly. For dispensing more frequently than monthly in this group the pharmacist needs the permission of the prescriber.

If you have a strong view about the frequency with which the patient should receive the medicine please talk with the pharmacist. More frequent dispensing can still be undertaken in the following groups:

- **‘Safety’ medications** already have rules around their dispensing, for example Class B controlled rugs and tri-cyclic antidepressants. PHARMAC has added codeine and buprenorphine with naloxone (Suboxone) to the safety list. There is no need for the prescriber to annotate safety medicines. You just need to specify the period of supply. If patients have other medicines co-prescribed with safety medicines, the pharmacist can dispense them at the same time if they consider the patient would benefit. You don’t need to do anything as the pharmacist determines this.

- **Trial medicines.** You can prescribe an initial shorter dispensing period for patients who are starting a new medicine or having a dose change. You need to write ‘trial’ or ‘trial medicine’ on the prescription but don’t need to initial it. This rule hasn’t changed but MedTech has incorporated a ‘trial’ button in its software.

- **Monthly dispensing into Aged Residential Care and community residential care facilities** remains the same as the current rules. You don’t need to annotate the prescription, as long as either the prescriber or pharmacist includes the residential address and patient NHI number.

If you want more information on the Close Control rule changes this is available at www.pharmac.govt.nz/ccc or phone 0800 66 00 50.
More information about the LTC Service

**GPs to encourage eligible patients to register for LTC Service**

It is expected that referral to the LTC Service will be proactive and collaborative, with prescribers and Needs Assessment and Service Coordination (NASC) actively referring patients and sharing relevant clinical information, where appropriate.

Patients who are eligible but who don’t want to register for the LTC Service can still receive pharmaceutical services as a Core Service patient, and the pharmacist will use his or her professional judgement to provide service to that patient as the pharmacist sees fit.

Patients identified as meeting the InterRAI Medication CAP (as part of a home-based support needs assessment) would be considered to be automatically eligible for the LTC Service.

**Patients in the LTC Service will be registered with a particular pharmacy**

Pharmacists will start progressively assessing their high needs patients from 1 July 2012 and invite those eligible to register to receive dispensing and pharmaceutical support. LTC Service patients may still receive medications from another pharmacy, for example if they are out-of-town or after hours. If an LTC Service patient started regularly receiving pharmacy services at another pharmacy, the patient will be invited to transfer his/her registration to the other pharmacy.

**Health professionals will share clinical information on LTC Service patients**

The pharmacist will use an eligibility assessment tool which assesses medicines-related issues to determine if a patient is eligible for registration. Part of that assessment tool includes recommendations from other health professionals such as GPs and specialists. It is expected that the pharmacist would communicate the result of the assessment to the patient’s GP and any other relevant member of the patients health care team, for example a mental health nurse.

**Patients might receive their medicines on a different timetable**

The new service model allows a pharmacist to tailor dispensing to the individual. For example, a medicine can be dispensed every six to eight weeks instead of monthly or three-monthly. A patient on several medications could have his or her medicines regimen aligned to a common end date, so the patient need only visit the pharmacy and the prescriber once instead of multiple times. This frees up time for the pharmacist to spend with those patients who need extra support with their medicines.

**Pharmacists may provide compliance packaging as necessary**

Pharmacists will be able to continue to supply compliance packaging at the same level as 2011 until early 2013. They will then use their professional judgement to determine if a patient needs to use compliance packaging and, based on the frequency of dispensing, what charges (if any) may need to be made for the service.