

20 District Health Boards

**Community Pharmacy Service
Options for People with
Disabilities living in Community
Residential Support Services**

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 Pharmacy Services Agreement 2011. 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 residential support services are vulnerable, have intellectual, mental or physical disabilities and may also have personal health issues. They require special protection to ensure their needs are met so they can live an ordinary life in the community. This document is aimed at people with disabilities living in residential support services. The issues may, however, also be applicable to people with disabilities in supported living situations, and feedback on this would be useful.

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 residential support services 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 residential support services, 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/SVDZYSV>

Please type the link into your browser.

Email

PharmacyCommunity@dhbz.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 to People in Community Residential Support Services

The Process

Community pharmacy services to people in community residential support services may be more similar to those provided to people living independently in the community than the services provided to people in age-related residential care. In broad terms, community pharmacy services are provided as set out below. There may be some variations in the service model.

- The resident may register with a practitioner as their regular provider of urgent and non-urgent primary health services and be enrolled in a PHO, or the practitioner may be contracted to service all the residents in the supported accommodation facility.
- The practitioner may write a prescription form itemising the pharmaceuticals the resident requires to improve their health and wellbeing.
- The scripts are usually written three monthly, although some items may be written close control (daily, weekly or monthly) where the person has particular needs, such as an intellectual disability or some mental health medications.
- The practitioner reviews the medication for each resident as necessary.
- The resident, or their agent (eg, support worker) takes the scripts to the community pharmacy either they or their facility choose.
- The community pharmacist checks the scripts, packs the medications and provides them directly to the resident and/or their key support worker, along with necessary information and advice.
- The resident pays a co-payment and any part charges for the scripts. People who used to live at Templeton or Kimberley before being deinstitutionalised are exempt from co-payments.

- In some instances the pharmacist will pack and deliver medications to the facility.
- The community pharmacist may provide education, advice and information to the facility staff to assist the management of medications.
- The community pharmacist will engage as necessary with the practitioner about the treatment regime, 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 community residential support services.

Residents

About 9,042 people access residential support services while in receipt of a main benefit; 1005 with a physical and/ or sensory disability, with the remaining 8036 having psychological (including drug and alcohol) or intellectual disabilities. The MOH's Disability Support Services team funds residential support services for more than 7,000 in total, comprising 6,000 people with intellectual disabilities and 1,000 people with physical and sensory disabilities. The 20 DHBs fund approximately 2,000 people in Mental Health and Addiction Services supported accommodation. Disability Support Services, Ministry of Health, also fund residential support services for people requiring long-term supports for Chronic Health Conditions [at 31 August 2010, total numbers were age 15-34 (8), 35-49 (75), 50+ (274)].

Mostly the residents are under 65 years.

Approximately 800 of these residents are living in aged residential care facilities.

Residents are provided access to GPs and pharmacies of their choice and mostly personally fund their medication part-charges, similar to those living independently in the community. The residential service provider is required to ensure that all high service users are registered with Work and Income and their GPs and pharmacies. Service user part charges and blister packing costs are often a high cost to these people on limited income, funded from their disability allowance.

For the year to 30 June 2008, people with intellectual disability were each dispensed an average of 5.8 different types of medications from community pharmacies – an average of nearly twice as many different types of medications as a community cohort.

The Close Control rules in the Pharmaceutical Schedule permit people with intellectual disabilities to receive monthly scripts but we don't know if all do. Some people with severe mental illness may have some medications (antipsychotics and/or medications for chronic conditions) dispensed via daily, weekly or monthly close control, but again not all do.

The administration and storage of medications for people in community residential support services is managed by Community Support Workers, not Registered Nurses, so there is low clinical capacity in such residential facilities and a strong need for good packaging compliance (ie, blister packaging accuracy). Many clients (especially those who are

higher functioning with intellectual disability and also physical disability) self administer their medication. Some pharmacies have made simple adaptations to a pill tray to increase the possibility of this, eg, punch code for the blind, bigger lettering (this could also be done in colours for people with intellectual disability and so on).

The National Health Committee has identified that many adults with an intellectual disability have ongoing and complex health needs that are often not well recognised and treated. Adults with an intellectual disability may find it difficult to access health care without support and often depend on others to recognise their need for health services and help them communicate their needs. After reviewing the pharmaceutical records of more than 2,500 adults with an intellectual disability, the NHC expressed concern that many were over-medicated, using outdated medication, were unable to access specialist review, and 40 percent were being treated with psychotropic medicines without having ever been diagnosed as having a psychiatric condition or having behavioural issues addressed.

Most people with an intellectual disability are on a low income, which creates a barrier to timely and appropriate health care. The Disability Allowance is specifically for disability-related costs, and the current maximum allowance is \$57 per week. These items may cost more than the weekly personal allowance

that can be retained from an income support benefit.

People who are mandated under orders (such as IDCC&R and MHCATT) may have the full costs of their medication covered.

People who were part of the Templeton or Kimberley deinstitutionalisation processes should not be paying pharmacy charges or co-payments, but it appears many are.

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.

Community Residential Support Services

The residential service provider is required to ensure that all high service users are registered with Work and Income, general practice/PHO and pharmacies. Service support staff liaise with practitioners and may support the resident to fill their prescription.

The Pharmaceutical Schedule allows people with an intellectual disability or those receiving some mental health medications to receive monthly supplies of medication. Services or residents may also request that pharmacies provide compliance packaging for storage and safety reasons.

Community Pharmacists

The community pharmacist receives the resident's prescription form, packs the pharmaceuticals and provides them to the resident directly, or to their support worker. Some pharmacies may use robots to pack medications in compliance packs.

The community pharmacist may provide education, advice and information to the residence staff to assist them to support the resident to manage their 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, 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 Residents in Community Supported Accommodation

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 community supported accommodation facility	
Family member of a resident	
General practitioner	
Secondary care practitioner	
Community Pharmacist	
Service provider (owner)	
Service manager	
Community Support worker	
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 Residence 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 ↔ Residence ↔ Facility ↔ Community Pharmacy:

working as a multidisciplinary team

We are interested in the factors that improve or limit the quality of multidisciplinary teamwork and interaction between practitioners, residents, residences and community pharmacy – and also most help maintain or improve residents’ health.

7. Are prescribing decisions for people in community supported accommodation similar, or different, to prescribing decisions for people living independently in the community?

	Reasons
Similar	
Different	

8. What factors do you think contribute most to effective working relationships between prescribers, pharmacies, residents, residences 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, may have frequent hospital admissions and/or infrequent medication reviews. 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				
Monthly Close Control				
Daily or weekly Close Control				
Specified response times for scripts to be filled and therapy commenced				
Individual residents' access to Pharmacists				
Information and education to residence staff				
Clinical capacity of residence staff				
Residence 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 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 residence	
Other?	

Additional Perspectives

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

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
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 per cent).
Close Control	<p>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.</p> <p>The Schedule permits pharmaceuticals to residential care facilities, and to patients with an intellectual disability, for example, to be dispensed via monthly close control.</p> <p>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</p>
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.
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 Act 1992
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).

Term	Description
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