New service model for community pharmacy

There are significant and far reaching changes that occurred with the implementation of the new Pharmacy Services Agreement, which started on 1 July 2012. It is important that clinicians understand what changes are occurring.

Did I know anything about this?

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, which included a representative of the RNZCGP, met every six weeks until November 2011. 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. All organisations are very supportive of the approach.

Why change?

Under the previous model, pharmacies were paid on volumes of medicines dispensed. The resulting expenditure growth in pharmacy dispensing costs has become unsustainable, and the linking of funding to volumes had little relationship with patient outcomes. In 2009/10 the total cost of dispensing fees was $320 million, of which $82 million was spent on dispensing medicines under the Close Control Pharmaceutical Schedule Rule (now referred to as "Dispensing Frequency"). Of the $82 million spent on Close Control, more than half ($46 million) was spent on weekly dispensing.

The Close Control regulation has provided a mechanism for pharmacies to dispense more frequently to some patients. However, it appears that there is currently an element of over-use of this regulation. Aside from trialling new medicines, weekly dispensing should be an exception, rather than a rule, e.g. for people with safety issues.

The new funding model is designed to be patient-centred and will allow pharmacists to better tailor medicines adherence and compliance services to patients, particularly those with multiple co-morbidities and taking many medicines. Pharmacists will also be encouraged to work with doctors and nurses and become part of the health care team.

The key strategic drivers for the new model include:

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

In practical terms what will the pharmacy be doing?

The key activity is that Pharmacists will now be identifying patients who qualify for focussed care, under the Long Term Conditions (LTC) rules. These patients are likely to have complex co-morbidities and/or have difficulties with medicines compliance. An objective assessment tool to aid Pharmacists in identifying patients for LTC has been developed and piloted in 30 pharmacies. General Practitioners can refer patients to be assessed for eligibility for the LTC service, by indicating this on a prescription, e.g. "Refer for LTC assessment", or by contacting the pharmacist directly. Other health professionals may also refer patients for LTC assessment, as can family members or the patient themselves.

Pharmacists will be funded to assist in the management of these patients, and one of the outcomes will be to determine the dispensing frequency of their medicines. If patients are compliant with their medicines and do not require special care, it is likely that the pharmacist will reduce the dispensing frequency. Patients who are currently dispensed medicines under Close Control can be maintained on this regimen ("Dispensing frequency") until they are assessed for eligibility for the LTC service. Pharmacists have until 31 January 2013 to assess these patients, so the change does not have to be immediate.

The LTC assessment tool is available from:
www.centraltas.co.nz/DHBSharedServices/Pharmacy/LatestRelease/tabid/242/Default.aspx

As a doctor/nurse what do I have to do?

- In the first instance, understand the changes! It will be worthwhile inviting your local pharmacist(s) over to talk to them about how you can work together. Some areas are holding combined general practice/pharmacy meetings and we would encourage you to attend these.
- Recognise that you are no longer required to stipulate the frequency of dispensing, or write "close control" on your prescriptions; the pharmacist will determine the dispensing frequency.
- If you do wish to specify the dispensing frequency, you need to endorse the prescription with the frequency of supply, e.g. 7 days + 11 repeats. You do not need to write "Close Control".

So what has not changed?

- There will continue to be a list of "safety medicines", such as tricyclic antidepressants and antipsychotics, which can be prescribed more frequently. The period of supply is determined by the prescriber. The prescriber should specify the maximum quantity to be dispensed at one time. Individual items do not need to be initialled. Codeine and buprenorphine with naloxone have been added to the safety medicines list. If you have co-prescribed other (non-safety) medicines, the pharmacist will determine if these should be dispensed at the same frequency as the safety medicines. No further notation is required for these medicines.

The list of safety medicines is available from:
www.pharmac.govt.nz/ccc

- Some PMS systems have an "initial trial period" prescribing function. This system will remain in place. This means that you can prescribe, for example, one week of medicine to assess tolerance, and, if tolerated, the patient can return to the pharmacy to collect the rest of the prescription.
- Dispensing frequencies for residential care facilities will not change.

What about compliance packaging (Blister packs)?

The previous Close Control regulation was frequently used as a mechanism to fund blister packs. That funding mechanism will no longer exist. Blister packaging will be available, but the cost for this is at the discretion of individual pharmacies.

Where do I learn more?

Further information about the new Pharmacy Service Model and changes to dispensing frequency rules is available from:

- **www.pharmac.govt.nz/ccc**
- **www.centraltas.co.nz/DHBSharedServices/Pharmacy/LatestRelease/tabid/242/Default.aspx**