Enhanced Residential Care Pharmacy Services

Metro Auckland District Health Boards' Consultation

(8 October – 30 November 2018)

Summary of consultation feedback

Prepared by Waitemata DHB

January 2019

Executive Summary

Over eight weeks, from 5 October to 30 November 2018, the metro Auckland District Health Boards (DHBs) sought the views of pharmacists, prescribers, Facility managers, other health professionals, sector representatives and consumers on the direction of the proposed Enhanced Residential Care Pharmacy Services.

The primary consultation channel was an online questionnaire, through which 136 submitted responses were received. There were four email responses submitted by individuals/organisations. Overall, there were around 40 businesses and organisations represented through the submissions. There was general consensus that the proposed service model and service components will meet the needs and expectations of residents, Facilities and healthcare providers. There were a number of concerns related to the implementation of the proposed model and this requires additional planning and coordination by DHBs, in partnership with key stakeholders. The DHBs intend to evaluate these concerns in more detail and will communicate with stakeholders once a decision is finalised by the Boards on a way forward.

Key Findings

- **68%** of respondents agreed that the four broad service components were appropriate pharmacy services to be delivered to Facilities
- **53%** of respondents agreed that the high level benefits could be realised through the proposed service model. However, 26% of respondents were undecided about the benefits
- **78%** of respondents agreed that all residents should receive holistic and patient-centred medication reviews to ensure that the medicines prescribed are clinically appropriate, safe and beneficial with optimal dosing
- **85%** of respondents agreed that everyone living in residential care should have an electronic medication chart that is utilised by pharmacists, prescribers and Facility staff
- **82%** of respondents agreed that pharmacists should conduct regular training for Facility staff and/or prescribers about medicines (for example, safer medicines management & administration, medicines storage, medicine crushing guidelines, pain management)
- **75%** of respondents agreed that pharmacists should provide support and guidance to ensure Facilities meet the medicine management expectations under the Health and Disability Services Standards
- **83%** of respondents agreed that a performance framework should be formed to inform continuous improvement of service delivery for pharmacies over time
- **70%** of respondents agreed that pharmacists are well placed to conduct investigations into dispensing and/or administration processes/errors, and to work with Facilities on how improvements can be made
- **53%** of respondents said that there were gaps in the proposed model.

Key concerns

- The current pharmacy service provision is satisfactory and does not require DHB intervention
- The DHBs' intention to have limited number of pharmacy providers with exclusivity to deliver services to Facilities
- The lack of funding to deliver the proposed service model and potential additional costs to the health system
- The need for a comprehensive change management and implementation plan.

Metro Auckland DHBs: Enhanced Residential Care Pharmacy Services Consultation

Background

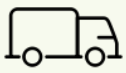
Metro Auckland DHBs have agreements with community pharmacies for the ongoing supply of medicines and advice to residents living in age-related residential care (ARRC) and community residential care (CRC) facilities ('Facilities'). Community pharmacies are funded through a fee-for-service model and the amount of funding received by pharmacies is dependent on the volume of medicines supplied.

Pharmacy service provision varies greatly ranging from small pharmacy providers servicing a limited number of Facilities, through to large-scale operations covering multiple Facilities across the Metro Auckland. There is also variability in the level of medicines management services and timely delivery of medicines to Facilities.

The Metro Auckland DHBs proposed to implement an Enhanced Residential Care Pharmacy Services to ensure a consistent, safe and effective service provision for all residents. Furthermore, it was proposed that DHBs would select a limited number of community pharmacy providers with an exclusive right to provide the services to the Facilities. Therefore, the Facilities will be required to receive funded pharmacy services from one of the selected pharmacy providers only.

The enhanced pharmacy services model aims to achieve consistency for all residents through holistic, patient-centred medication reviews that ensure prescribed medicines are clinically appropriate, safe and beneficial to patients across all the Facilities.

The enhanced pharmacy service being proposed has four key service components:



Supply and distribution of medicines, using automated dispensing technology to improve efficiency and minimise dispensing errors in the community.

Medicines management services to ensure the safe and appropriate use of medicines in a high-risk population group. Pharmacists will complete detailed medication reviews to identify medicine-related issues that are likely to cause avoidable patient harm and support the use of electronic medication charts.

Health information and education provided to give advice, support and counselling to people involved in medicines management. Pharmacists are experts in medicine management and will provide medicine information and regular in-house training to prescribers and Facility staff.

Performance framework and monitoring will inform continuous improvement of service delivery over time. The performance framework will also support improved data gathering to determine future areas of focus.

Consultation Aim

To provide the Metro Auckland DHBs' Boards insights to inform their decision on the proposed Enhanced Residential Care Pharmacy Services. The aims of the consultation were to:

1. Seek feedback on whether the proposed change and service model meet the needs and expectations of patients, Facilities and healthcare providers.
2. Understand any issues or limitations that should be considered.

Consultation feedback forms the basis for the Metro Auckland DHBs' Boards to inform their decision-making to further develop and improve the pharmacy services delivered to people living in residential care facilities.

Methodology

Consultation information and survey questions

The consultation process took place to engage with community pharmacists, Facility managers, residential care providers, residents and prescribers. A detailed consultation document was released with information about the current services delivered by pharmacies to ensure that stakeholders have a comprehensive understanding of the scope of this consultation. The consultation document also included information relating to the proposed service model and case for change.

The questions were designed to gain insight into the views on the following areas:

- Proposed service components
- Benefits of the proposed service model
- Any risks to residents, pharmacists and other health professionals
- Gaps in the proposed model
- Limited number of pharmacy providers
- Cost of service to residents and Facilities

Demographic information was requested from participants to help understand the perspectives from various groups of stakeholders and to understand any differences in perspective.

Consultation plan

The DHBs used a number of different ways to seek comprehensive feedback from a wide range of stakeholder groups. Respondents could provide feedback via an online survey, a written feedback form or by writing directly to the DHBs. The DHBs also engaged with community groups to provide information about the consultation and to help them understand how the consultation might impact on residents who receive pharmacy services.

The following activities took place to provide stakeholders with information about the consultation:

1. *Online consultation survey*

The BuzzChannel platform was used for online feedback. The website included a link to the consultation survey, consultation documents (**Proposal for Change** and **Community Information Feedback Form**) and details of forums which participants could attend.

Within the online survey, the only compulsory questions were name and email or postal address. These were requested to ensure that feedback was genuine and to manage instances of people providing multiple responses at events and / or online.

2. *Community forums and meetings*

The DHBs held three forums at different locations, Auckland City Hospital, North Shore Hospital and Middlemore Hospital. These were public events open for both health professionals and consumers. An option was also given for anyone to request a DHB representative for external group or network meetings.

DHB representatives attended a number of meetings to raise awareness about the consultation and encourage feedback (**Appendix 1** – Schedule of meetings). These were directly towards community groups, as well as health professionals who work in the residential care sector. The meetings include:

- Auckland DHB Age Residential Care Steering Group
- Residential Aged Care Integration Programme meeting
- Health of Older People's Stakeholder Group (includes representatives from Grey Power and Aged Concern)
- Health Link North Board meeting
- Health Link Waitakere Board meeting
- Waitemata DHB Age Residential Care Providers' Forum
- The Asian Network Inc meeting

Attendees of these meetings were encouraged to provide written feedback through the online survey or directly to the DHB in writing or by email.

Presenters were encouraged to keep within a structured format for presentations to reduce the risk of bias, but to provide time for discussion throughout the forum to ensure that participants at meetings had the opportunity to raise questions.

Consultation promotion

The consultation was promoted through:

- DHB websites and social media accounts (Facebook) and staff intranet (online link)
- DHB distribution lists for community pharmacy and age-related residential care providers
- Key pharmacy sector representative groups:
  Pharmacy Guild NZ, Pharmaceutical Society NZ and Green Cross Health
- Ministry of Health distribution lists for disability support service providers
- Reo Ora Health Voice website current members across Auckland & Waitemata DHB (email)
- Media coverage – locally (picked up through PharmacyToday)
- Waitemata DHB Community Engagement Forum members and their networks
- Disability support network groups
- Counties Manukau Community Council

Consultation feedback

The consultation was open for a period of eight weeks, from 5 October to 30 November 2018. The primary source of feedback was from an online survey, through which 136 submissions were received. There were 4 email responses submitted by individuals/organisations. Overall, there were around 40 businesses and organisations represented through the submissions (see **Appendix 2** – List of organisations). There were also seven duplicate responses received. All duplicate responses were excluded from the analysis.

In order to engage a wide range of stakeholders in the consultation process across the metro Auckland DHBs' region, three public evening consultation events were held. These events generated a lot of interest and were attended by approximately 180 people. The DHB representatives also attended a number of meetings and forums to engage with Facility managers/staff and consumers. Furthermore, the DHB representatives welcomed invitations to meet pharmacy owners/managers and Facility managers individually.

As a part of the survey, respondents were asked to identify the DHB district where they provided healthcare services or their DHB of domicile for residents/families. The majority of responses received were from the three Metro Auckland DHBs, with 39% of responses from stakeholders within the Waitemata DHB district (Figure 1). The majority of responses were received from the pharmacy sector, ARRC sector and residents/family members (Figure 2).

Figure 1: Proportion of responses by District Health Board region (n=140)

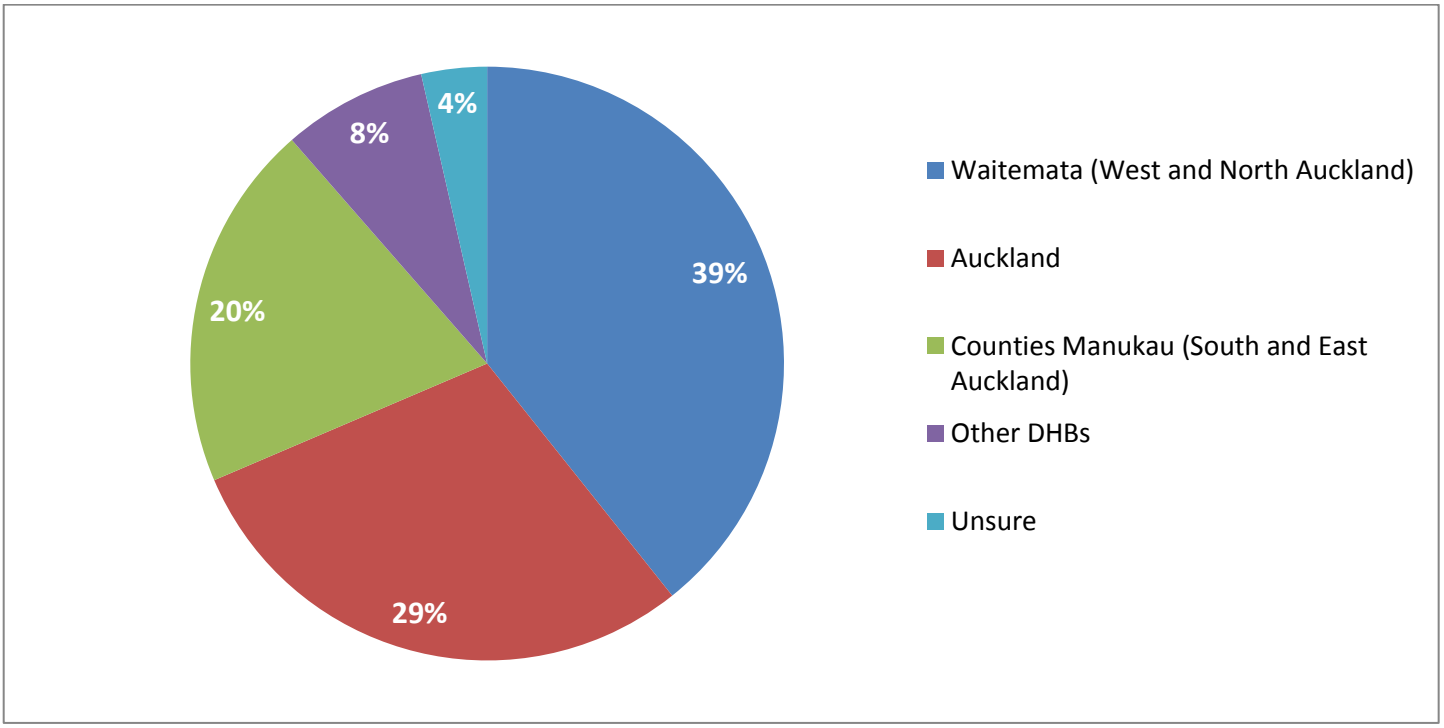
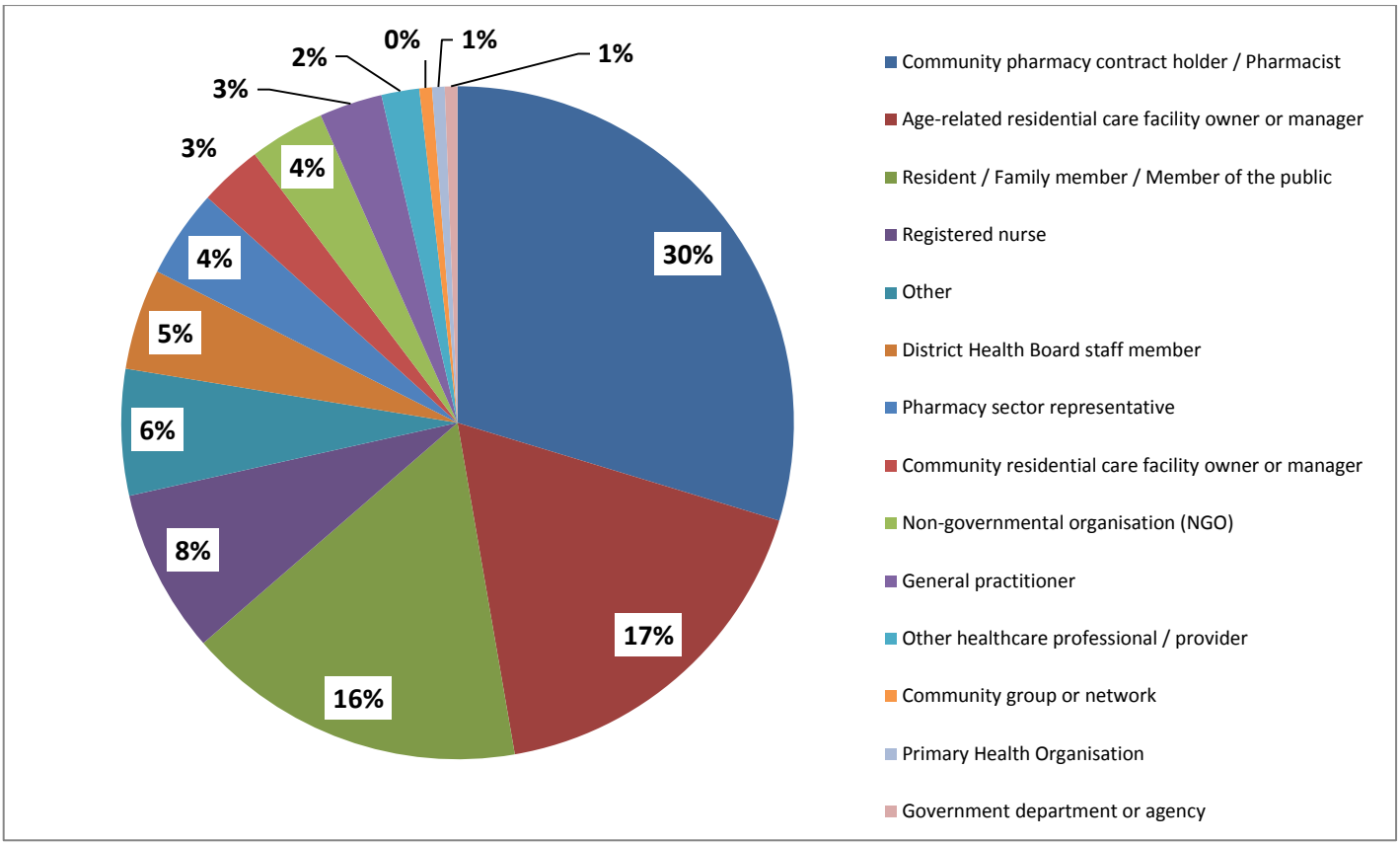


Figure 2: Percentage of respondents by professional affiliation or service and community (n=165)

Note: Respondents were allowed to select multiple options



Consultation Findings

This section focuses on presenting a summary of the feedback received in response to the questions raised in the consultation document. The summary includes both quantitative and qualitative responses. The feedback helped to gauge the level of support of the proposed model of care and to highlight areas for further improvement. Based on the thematic analysis, qualitative responses received are grouped into the four service components: Supply & Distribution, Medicines Management Services, Health Information & Education, and Performance Framework & Monitoring.

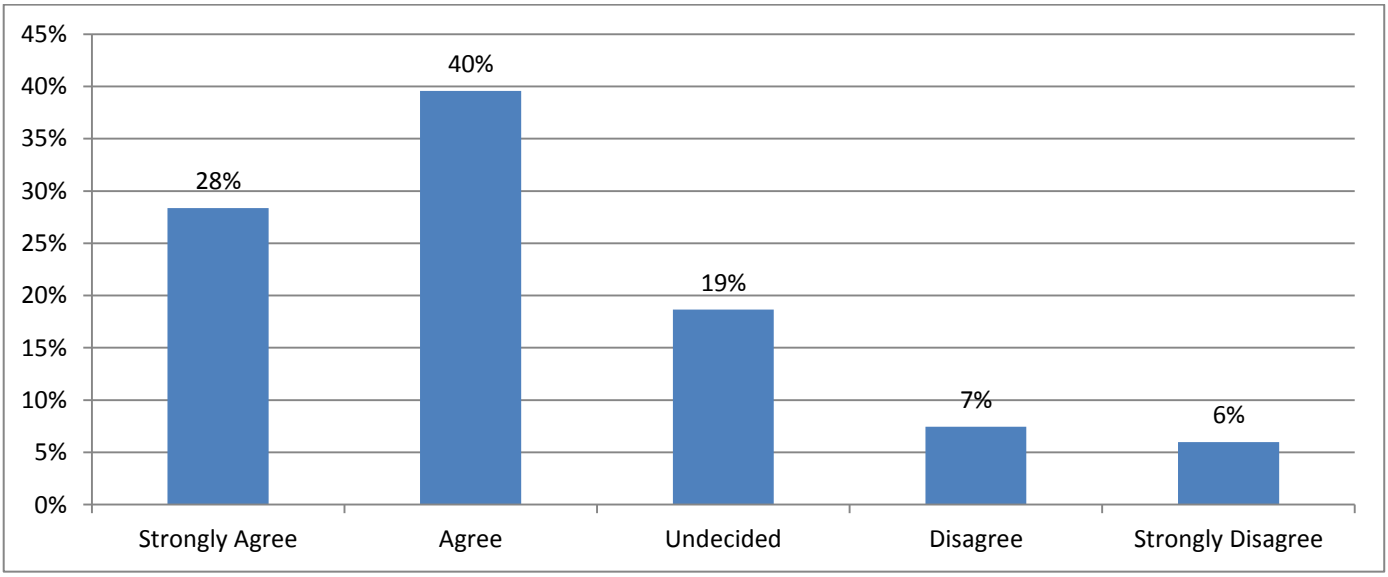
Overall service model

As shown in Figure 3, there is overall support for the broad service components proposed in the service model.

68% of respondents agreed that the four broad service components were appropriate pharmacy services to be delivered to Facilities (Figure 3)**.** Respondents felt that automation is crucial to the supply of medicines and may help to improve efficiency. They also saw opportunities with pharmacists conducting medication reviews and the implementation of electronic charting systems. Furthermore, they appreciated the importance of in-house education for facility staff and prescribers.

"There is plenty of room for pharmacists to reduce polypharmacy and the associated health costs related to them" – (Pharmacist)

Figure 3: Proportion of respondents who agreed that the four broad service components are appropriate pharmacy services to be delivered to Facilities. (n=134)



The consultation document highlighted a number of benefits that can be achieved from the proposed service model. These benefits include:

Residents

- Standardised provision of clinical services and medicine supply
- Reduced avoidable medicine harm
- Prevention of adverse events associated with polypharmacy
- Patient-centred services designed to meet specific health needs.

ARRC/CRC providers

- Increased capability to respond to medicines management needs of residents through the ongoing educational and advisory support offered by pharmacists
- Increased certainty as Facilities can expect a standardised level of clinical services and distribution of medicines
- Improved support to meet HDSS audit criterion related to medicines management and reduce medicines management issues identified through audits.

Prescribers

- Improved management using electronic medication charts, reducing the administrative burden
- Enhanced collaboration between pharmacists and prescribers
- Improved ease of transfer of medicines information between various health professionals
- Increased capacity to respond to residents' health needs using pharmacists' expertise in medicines management.

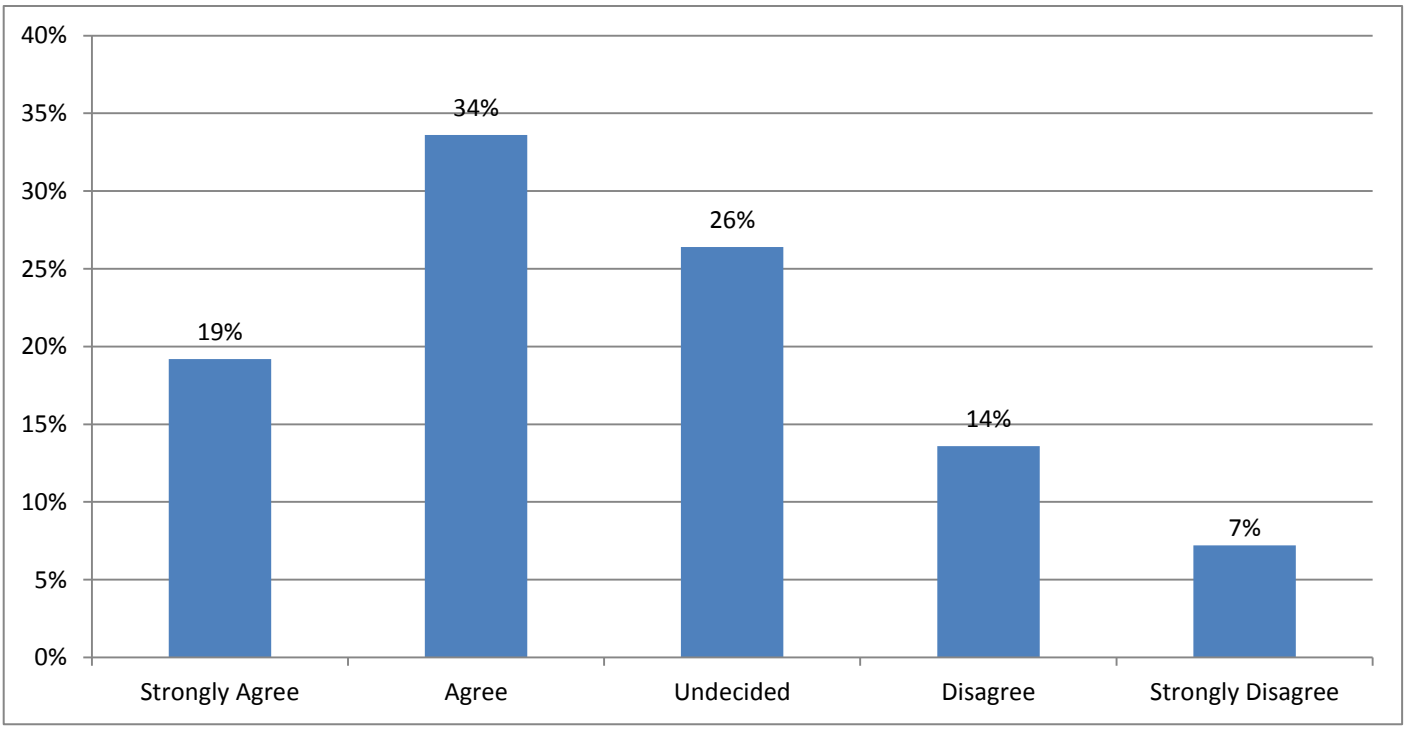
Pharmacies

- Pharmacy providers selected through this procurement process will have exclusivity to provide the service to Facilities across metro Auckland. This provides a level of assurance to pharmacy providers allowing for investment into new business models, innovative technologies and to improve service quality. The proposed model is likely to lead to the development of specialist services that allow pharmacists to work at the top of their scope.

53% of respondents agreed that the high level benefits can be realised through the proposed service model (Figure 4)**.** However, 26% of respondents were undecided about the benefits.

"This proposed service model I believe will enhance collaboration between pharmacist, doctors and nurses. Leading to the best possible health outcomes for residents at aged care facilities." – (Pharmacist)

Figure 4: Proportion of respondents who agreed that the high level benefits can be realized through the proposed service model (n=125)



The majority of respondents agreed that the proposed service components would improve medicines management and benefit residents. For example:

> *"Pharmacists can perform at the top of their scope by providing a clinical based medication review which can significantly be benefiting to residents residing in residential care facilities." – (Pharmacist)*

Some respondents felt that the benefits should be happening now under the current service model, and that the proposal lacked detail on the service specification and funding to comment on potential benefits to stakeholders:

> *"At present there is limited information about the quantity and quality of benefits the proposal will realise. The proposal should be developed further to reference current system performance. Proposed benefits would be more meaningful against a reference point that enables fair and measurable comparison of the current state with the proposed future state." – (Pharmacist)*

Respondents were also asked to provide feedback on other benefits that may be realised through the proposed service model. Examples of the benefits raised by respondents include:

- Residents would have assurance that they are receiving good quality services from the pharmacy and have the appropriate access to pharmacist services.
  "Safer for residents and those supporting them in the community" – (Non-government organisation)
  "Greater transparency on medication strategy for individual residents so relatives have greater confidence and understanding of treatment strategies" – (Resident/Family member/Public)
- Pharmacy providers will have greater clarity about the financial sustainability of their business.
  "Pharmacies can use the scale to create a viable business model if guaranteed a portion of the market" – (Pharmacist)

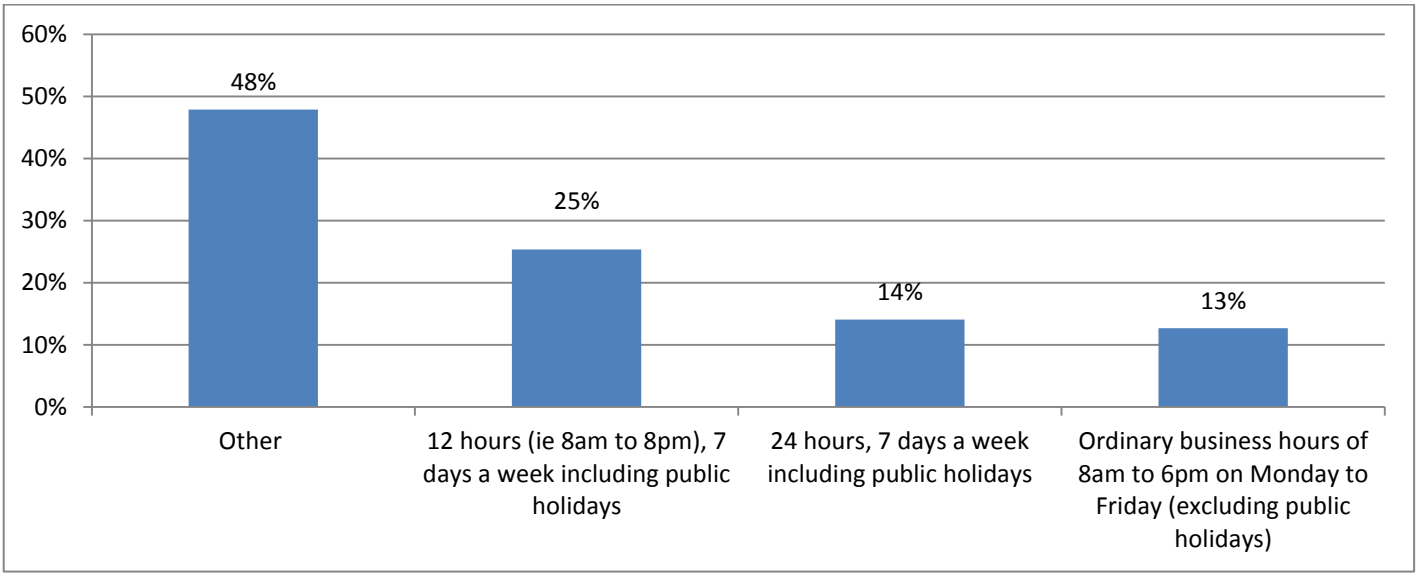
Service Component 1: Supply & Distribution

The proposed model aims to enhance the supply and distribution of medicines through the use of automated dispensing technology to improve efficiency and to minimise dispensing errors in the community. The proposed model means that pharmacies will deliver medicines to a group of Facilities to achieve economies of scale. The frequency of supply will need to be determined based on the frequency of prescriber visits (ie change in medicines or medicine dosages), resident and Facilities' needs (ie the schedule of the Facility and its staff). The supply and distribution of medicines will follow a "Just-in-Time" concept to minimise unnecessary waste and rework.

- Respondents had very mixed views on the benefits of using automated dispensing technology. Some respondents believed automation may improve efficiency, but many questioned its ability to reduce dispensing errors. Furthermore, there were concerns about the cost of implementing the technology and the ability to make medication changes promptly.

- Respondents had mixed views on the level of access for the supply and distribution of medicines (Figure 5). The minimum requirement was service accessibility from Monday to Saturday. A majority of respondents provided alternative options such as:
    - Ordinary business hours and on call after-hours
    - Monday to Saturday (excluding public holidays)
    - After-hour arrangements for urgent antibiotics or controlled drugs (pain relief)
    - Level of access may differ between CRC and ARRC facilities
    - Utilising urgent pharmacies operating in hospitals for after-hours access

Figure 5: Level of service access expected by respondents for the supply and distribution of medicines (n=71)

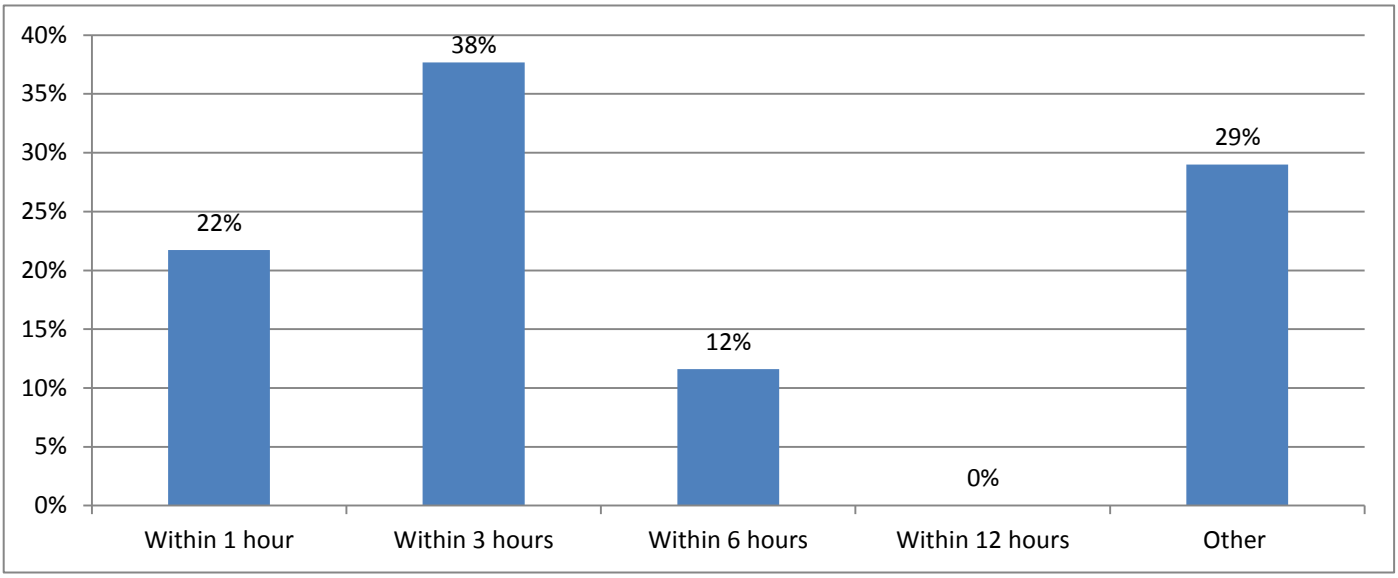


- 44% of respondents stated "once a day" delivery is expected for routine medicines and 32% provided other options (n=68), such as:
    - Three times a week
    - Fortnightly delivery because facilities do not have space to store one month's supply of medicines
    - Weekly delivery for residents who require multiple changes
    - Delivery times should be dependent on the facility needs

- 38% of respondents said they expect urgent deliveries to occur within three hours and 22% expected a response within one hour (Figure 6). Although the respondents who suggested other options also agreed with urgent

deliveries within the one to three hours timeframe, many said that the urgency will vary depending on patient circumstances.

Figure 6: The time respondents expect pharmacies to be able to deliver urgent medicines to Facilities (n=69)



- Timely access to medicines was an important theme highlighted throughout the feedback. Respondents felt that communication was key to ensuring pharmacies provide responsive and timely delivery of medicines. The location of the pharmacy was also an important factor to ensuring residents receive medicines on time. Some respondents expressed concerns that Auckland traffic would negatively impact on the response times and respondents highlighted the importance of having sufficient pharmacy providers to provide geographical coverage. Others have also identified future delivery technology via drones.

Adherence packaging:

- 43% of respondents preferred Medico Pak and 26% preferred robotic medicines sachets (n=65). Respondents provided feedback that both options should be available and that residents and Facilities should be able to choose their preferred adherence packaging format.

Pharmaceutical waste:

Unused or expired medicines are commonly returned to pharmacies for safe and proper disposal. Feedback was sought on the main causes of pharmaceutical waste. Respondents identified the following causes that contribute towards pharmaceutical waste:

- Overprescribing
- Changes to medication (dose/form)
- PHARMAC's dispensing rule (28 days supply minimum)
- GP reviews during a patient's cycle of medicines
- Patient refusing medicine
- Poor communication
- Over-ordering by Facilities
- PRN packs
- Hospitalisation
- Patient movement
- Multiple prescribers

Respondents suggested the following solutions to reduce pharmaceutical waste:

- Pharmacists to review all PRN medicines and check stock levels, rather than issuing the medicines automatically.
- More frequent supply of medicines ie weekly or fortnightly quantities.

- Making non-urgent medication changes when the next supply of medicines is due rather than immediately to minimise unnecessary changes. This could also be discussed when pharmacists performs site visits and MDT meetings to collaborate with the prescriber. Furthermore, electronic charts may enable GPs to make a pending change.

Service Component 2: Medicines Management Services

The proposed model was developed to allow pharmacists to work at the top of their scope of practice to ensure the safe and appropriate use of medicines in a high-risk population group.

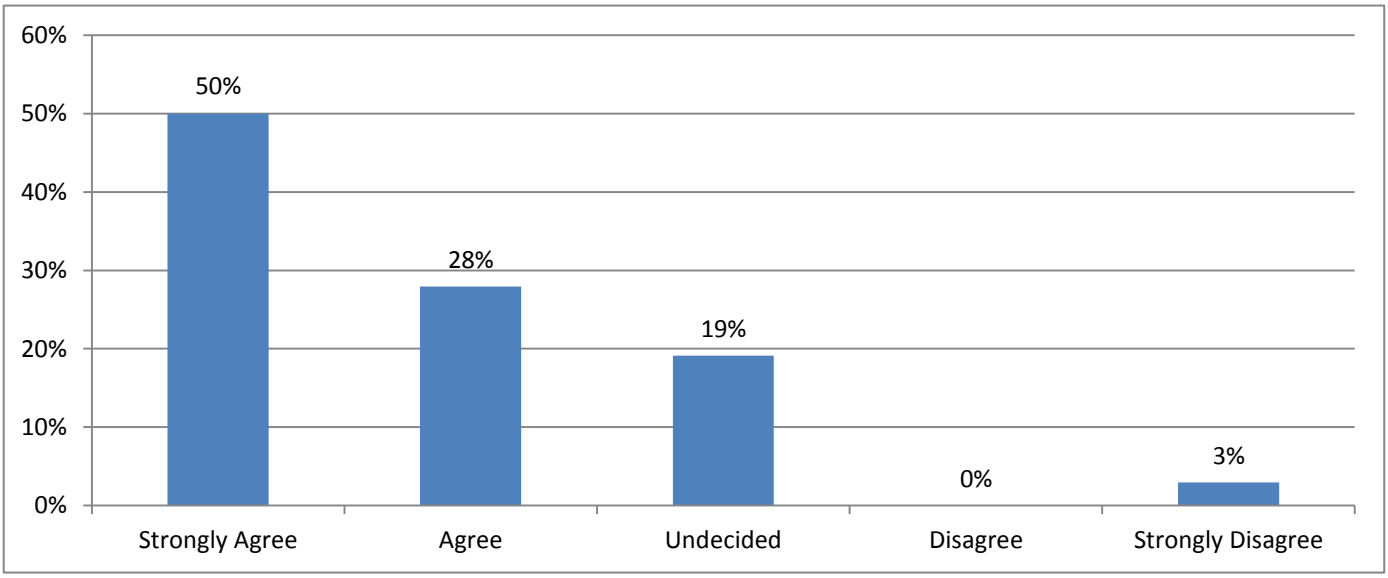
Medication reviews

The proposed model requires pharmacists to complete detailed medication reviews using primary and secondary care records to identify medicine-related issues that are likely to cause avoidable patient harm.

78% of respondents agreed that all residents should receive holistic and patient-centred medication reviews to ensure that the medicines are prescribed are clinically appropriate, safe and beneficial with optimal dosing (Figure 7)**.**

"There is plenty of room for pharmacists to reduce polypharmacy and the associated health costs related to them" – (Pharmacist)

Figure 7: Proportion of respondents who agreed that all residents should regularly receive holistic and patient-centred medication reviews (n=68).



- Respondents felt that medication reviews should be targeted to specific high-risk population groups in order to achieve the most benefit with limited resources. It was suggested that the reviews should be completed when residents meet a set of criteria.
  "Medication reviews should be conducted based on criteria. For example, number of regular medicines, hospital admission, significant health status change, and new diagnosis or GP request." – (Software vendor)

- Some respondents had concerns that standardised medication reviews will not meet the unique needs of individual residents.

- Respondents highlighted the importance of having a pharmacy workforce with the competency, experience and knowledge to conduct comprehensive medication reviews, and the potential need for specialist pharmacist roles to focus on medicines optimisation.

"Potential to think about medicines optimisation services as opposed to the general term medicines review (this would need competency in clinical assessment and expert knowledge of geriatric medicine and I would see it as an important role but one that could sit outside the community pharmacy contract to allow those with those skills to hold these types of contracts)" – (Pharmacist & Pharmacy Sector Representative)

"Based on the proposed draft service specification, for the DHB to achieve its desired outcome, pharmacists will need to undertake Medicines Therapy Assessments (MTA) to deliver the required medication review service. The New Zealand National Pharmacist Services Framework provides the training and accreditation foundation for this service. It includes a portfolio of evidence and formal assessment against PSNZ MTA standards, which have been endorsed by the Pharmacy Council. The MTA standards also require pharmacists to have defined pharmacotherapeutic knowledge and skills at a minimum post-graduate certificate level (or equivalent) plus at least TWO years patient orientated experience in a hospital, community or primary care setting post-registration." – (Pharmacy sector representative)

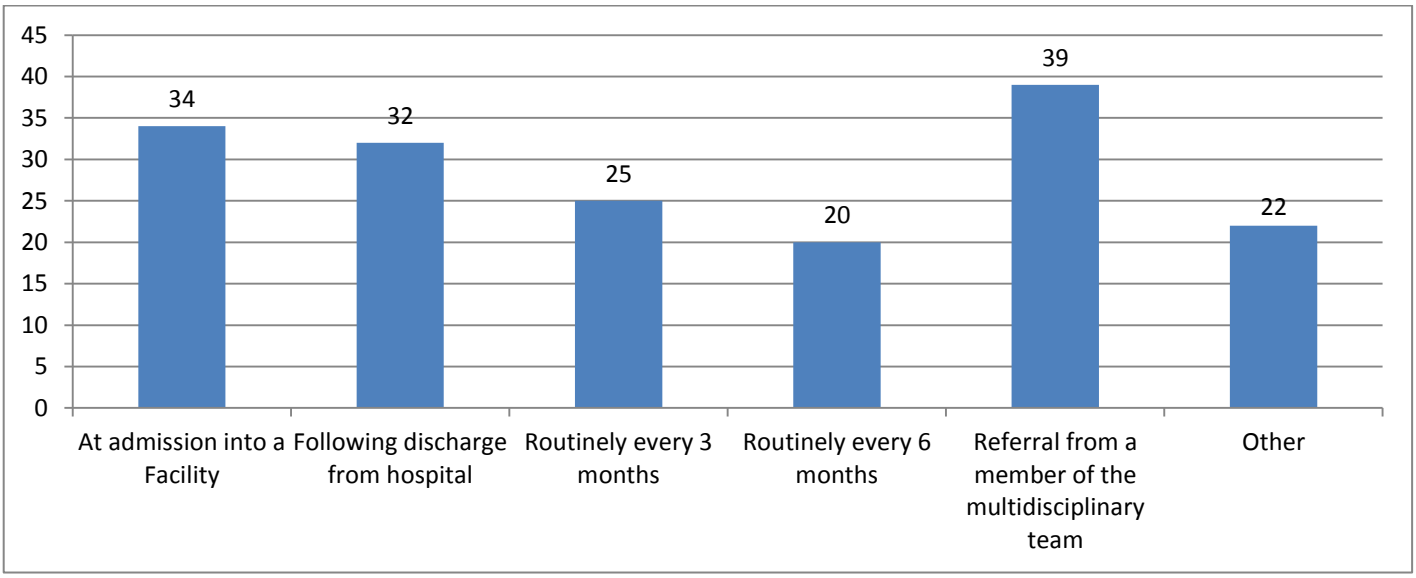
"Detailed medication reviews take a considerable amount of time to complete, often several hours. In order to make clinically appropriate, patient centred recommendations, a post-graduate diploma plus three to five years clinical experience working in a collaborative healthcare environment is required." – (District Health Board staff member)

- There was general consensus that medication reviews should occur at various times throughout the patient journey and also as a routine occurrence every three to six months (Figure 8). Respondents also felt that it was important that referral could be made from people in the resident's care team. The other options suggested included when any significant changes to medicines or health status occurred. Only few respondents suggested annual reviews.

  "For the mental health CRC facilities we are delivering to, the medicines are constantly reviewed by pharmacists and doctors, and our input into this is on an "as needed" basis and would not fit the annual review process. It is a daily or weekly process! Our role is to reconcile constantly and document and confirm changes." – (Pharmacist)

Figure 8: Point in patient journey when medication reviews should be conducted (n=172)

Note: Respondents were able to select multiple options.



- Some respondents were concerned that community pharmacists do not have access to all medical information required to complete a comprehensive medication review. Furthermore, the linkage between community pharmacists and secondary care specialists was important to ensure pharmacists had guidance on complex issues.

  "*The pharmacists need to have access to ALL medical history, not just that available at the facility - the [hospital] pharmacists at Waitemata DHB come out to the facility to do medication reviews having all this knowledge which community based pharmacists don't have access to." – (ARRC owner/manager)*

  "It is critical for the clinical pharmacist to have access to the expertise of geriatricians and psychiatrists on complex issues, and to be part of the DHB geriatric service." – (DHB staff member)

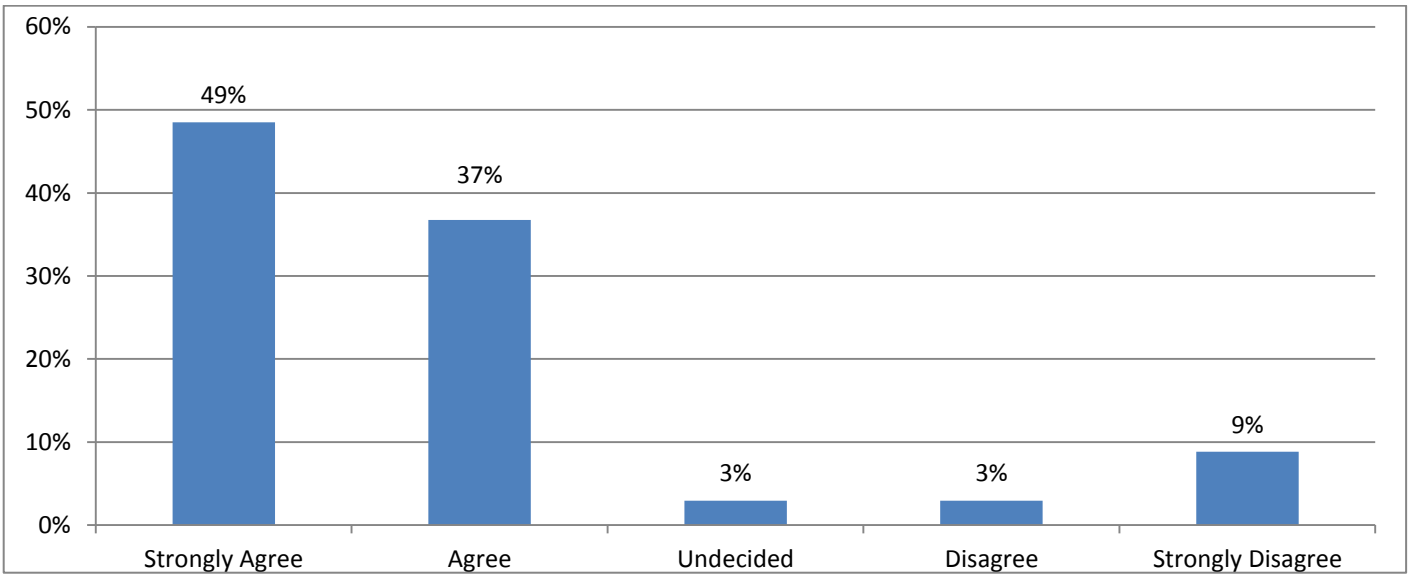
Electronic medication charts

The proposed model aims to support electronic medication charts for all residents. This ensures medicine records are available to the care team electronically via a shared platform and allows prescribers to chart medicines promptly without additional paperwork.

85% of respondents agreed that everyone living in residential care should have an electronic medication chart that is utilised by pharmacists, prescribers and Facility staff (Figure 9)**.**

"A centralised electronic medication chart improves quality and safety throughout the system by eliminating the issues paper-based systems create." – (Pharmacist)

Figure 9: Proportion of respondents that agree that everyone living in residential care should have electronic medication chart that is utilized by pharmacists, prescribers and Facility staff (n=68)



A majority of respondents agreed that people living in residential care should have an electronic medication chart that is utilised by pharmacists, prescribers and Facility staff. Facilities and pharmacies who have implemented these systems have highlighted benefits from their experiences. This includes the elimination of duplicating paperwork, improvement in patient safety and improved efficiency. However, some respondents questioned how mandating electronic charting could be done through the pharmacy services agreement, especially when Facilities and prescribers usually determine their own workflow.

"Reduce frequency of prescribers needing to authorise electronically charted prescription items. The fortnightly barrage of paper to sign, even though we use Medi-map, is a severe disincentive to be involved in residential care at all." – (General practitioner)

A key barrier to implementing electronic charting systems is the cost to providers, especially for smaller care facilities. The additional costs are related to hardware, internet access and software license fees. Furthermore, resources are required to ensure that staff are trained in the new system and this includes training to support all providers across the care team.

"[There is] Concern about any additional workload on prescribers in order to comply with the new system. While we support the change there is also the fact that well developed relationships with pharmacists will need to

change and this could have a negative impact." – (Primary Health Organisation)

"Some facilities have a small number of GPs looking after a small number of patients. In these cases there is reluctance for them to use the electronic charts. The pharmacy contract is not the best mechanism to get them to adhere [to the new system]." – (Pharmacist)

In addition, some respondents highlighted concerns related to the lack of integration between various practice management systems (ie practice management systems used by pharmacy, general practice and facilities that are capable of integrating with the electronic charting tool). There were also concerns raised on how providers would operate during a power or internet outage.

"Electronic charts have practical limitation - MediMap is not fully integrated with dispensing software, MediMap and Toniq have limited abilities charting Warfarin." – (Pharmacist)

Multidisciplinary team approach

The proposed service model is designed to ensure that outcomes of from medication reviews conducted by pharmacists will then be discussed at multidisciplinary team (MDT) meetings involving the Facility nurses, general practitioners and other medication prescribers. Suggestions for medicines to be stopped or changed or started will also be discussed with the residents and/or their family members, where appropriate.

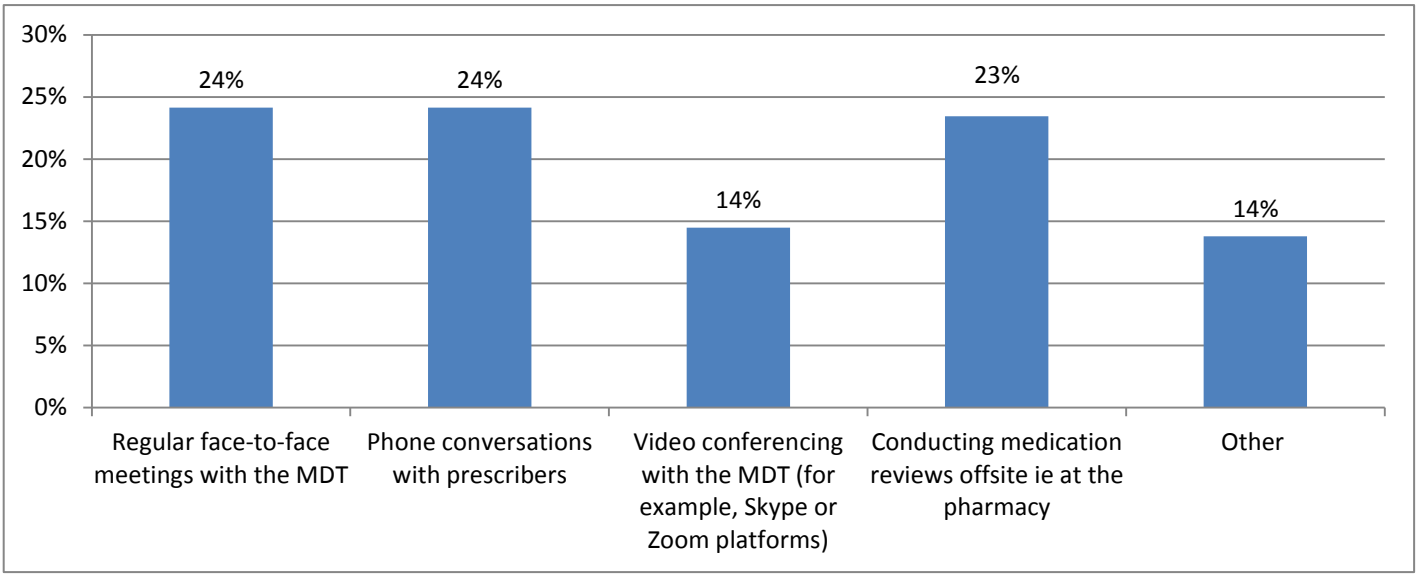
Respondents had views that the approach pharmacists take to be involved in the resident's MDT should be flexible and dependent on the patient/Facility needs (Figure 10). Some respondents are already participating in MDT meetings and communicating with prescribers by phone. The resident and their family were highlighted as active participants in the MDT. Respondents had concerns on the availability of health professionals in the care team to attend MDT meetings. Some respondents were keen to utilise new technologies such as video-conferencing.

"I believe there needs to be strong emphasis on the care team for the people this contract serves and a multi-disciplinary approach that is inclusive of the consumer and their families - this approach will ensure the consumer has the information and solutions they need to make informed decisions or for others to make this choice as appropriate - medicines optimization needs to be included for older people." – (ARRC facility owner/manager)

"It is not appropriate or within the scope of service provision document to dictate the requirement for participation of other health professionals. The directive that recommendations will be discussed at MDTs requires the prescriber and the nurse to be available to attend MDTs. The greatest barrier to a wider impact in my current role is that I cannot get more prescribers to attend MDTs due to their time constraints." – (DHB staff member)

Figure 10: Responses on the approach pharmacists should take to be involved in the resident's MDT (n=145)

Note: Respondents were able to select multiple options.



Community pharmacists currently deliver a broad range of services, for example aseptic dispensing of prefilled syringes, anticoagulation monitoring for warfarin and influenza vaccinations. Respondents were asked to provide suggestions on other pharmacy services that would complement the proposed service model. Respondents made the following suggestions:

- Blood sugar and cholesterol testing
- DNA testing for suitable prescribing
- Medicine Therapy Assessment
- Prefilled syringes
- Vaccinations
- Clozapine (monitored therapy)
- Smoking cessation
- Blood pressure monitoring
- Dose titration (insulin)
- Repeat prescriptions
- Substitute medicines
- Anticoagulation management
- Weight/nutrition management
- Wound management
- Gout management
- Patient counselling
- ADR database
- Medication formulary development and guidelines
- Cold chain assurance
- Performance monitoring and benchmarking
- Urgent access to palliative care medicines
- Pharmacogenomics

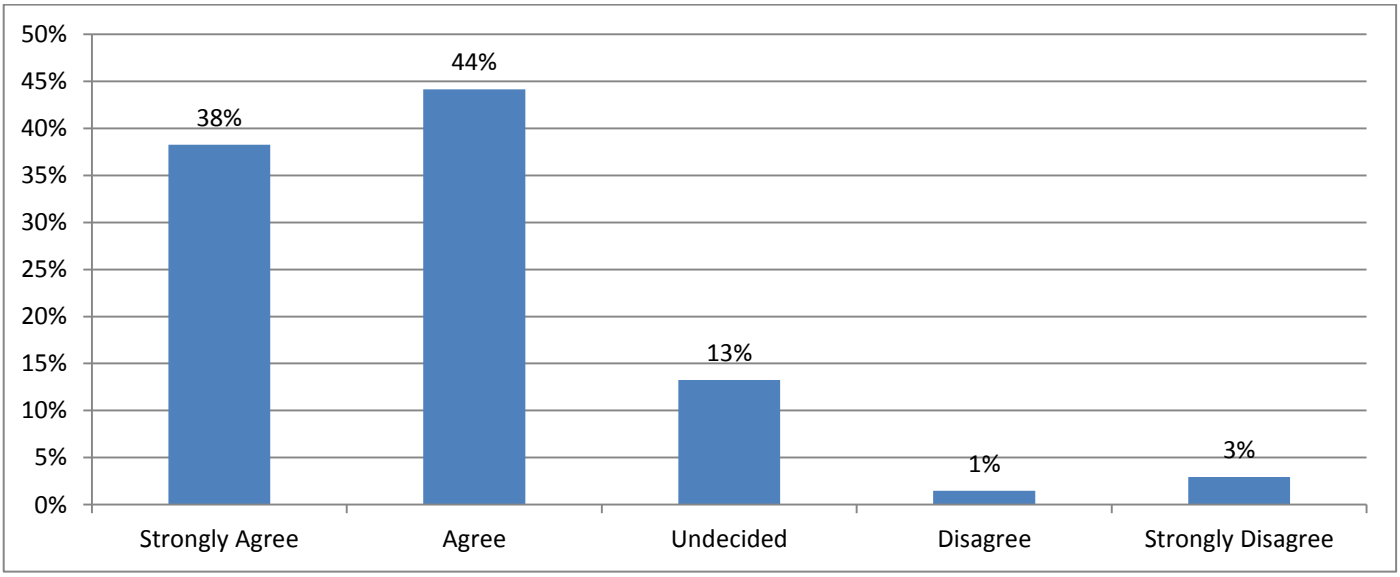
Service Component 3: Health information & education

The proposed model ensures that pharmacists will provide structured health information and education to Facility staff and residents. This means pharmacists will provide an appropriate level of advice and counselling to people involved in medicines management. Pharmacists are experts in medicines management and are well positioned to provide medicine information and regular in-house training to prescribers and Facility staff. The training will help to support the management of minor conditions and medicines management processes such as proper storage and safe administration of medicines.

82% of respondents agreed that pharmacists should conduct regular training for Facility staff and/or prescribers about medicines (Figure 11)**. Examples of training topics include safer medicines management & administration, medicines storage, medicine crushing guidelines and pain management).**

"We [pharmacists] are well positioned, as medicines experts, to be able to deliver training to other healthcare professionals." – (Pharmacist)

Figure 11: Proportion of respondents who agreed that pharmacists should conduct regular training for Facility staff and/or prescribers about medicines (n=68)



Some residential care facilities receive regular training from their pharmacists; however there are pharmacies that provide this service on an ad-hoc basis. Regular training for facility staff was an important factor due to regular staff changes at facilities and the ability to help reinforce key medication safety messages. Respondents supported pharmacist-led training in principle and felt that the training must be tailored to the needs and demands of residents, staff or prescriber. Providing training is considered to be time consuming and the funding required is a consideration to facilitate trainings.

"In house education is important and needs management commitment, and someone responsible for ensuring all staff are knowledgeable about their individual patient's health issues, and their medications." – (Registered Nurse)

"Pharmacists providing regular in-house training to prescribers raises concerns. Will this take up time which is unlikely to be well spent? It is hard to see this being an improvement on our current frequent collegial communications between GPs and pharmacist working out of the same building." – (General practitioner)

Respondents were asked to provide other focus areas where pharmacists can provide information and education:

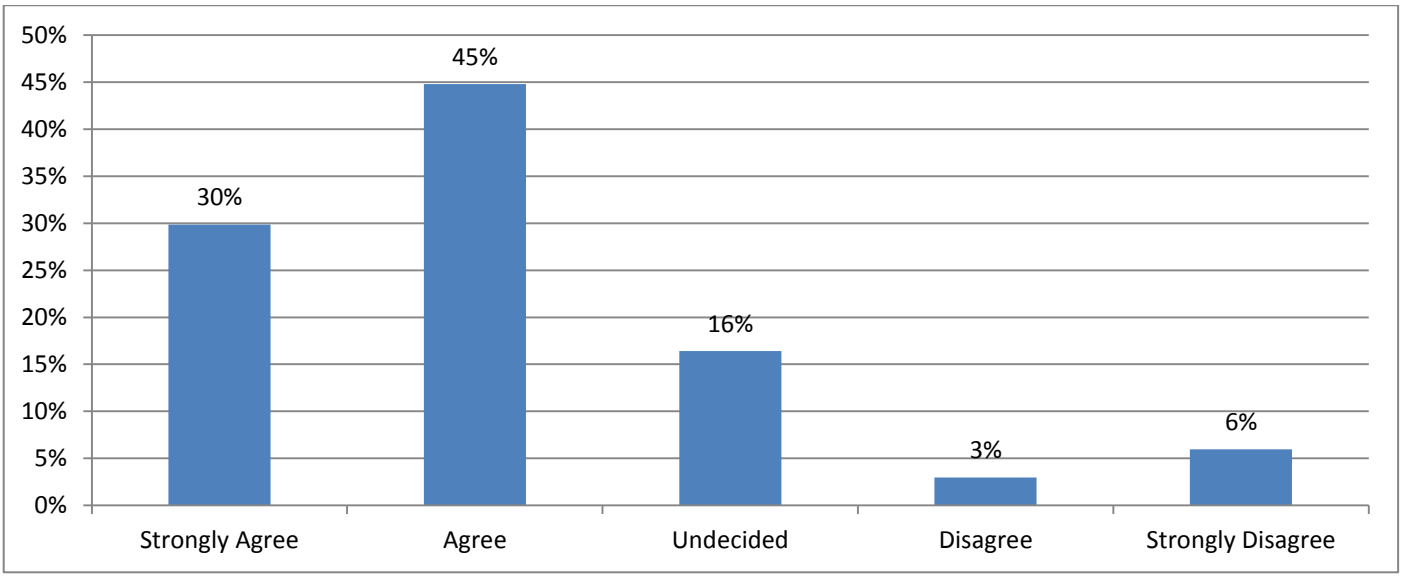
- Medicine interactions
- Medicine side effects
- Training talks on specific health topics ie hypertension, dementia, polypharmacy
- Overdose first-aid
- High-risk medicines
- Safe storage
- Health literacy
- Safe administration
- Handling cytotoxic medicines
- Audit compliance requirements related to medicines management)
- Adherence
- Patient monitoring – adverse reactions
- Impact on falls risk
- Aged Care Guidelines

Facilities must meet the medicine management expectations under the Health and Disability Services Standards. This includes ensuring a medicine management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols and guidelines. The proposed model would ensure that pharmacists are supporting Facilities in various aspects of medicines management to meet the relevant standards.

75% of respondents agreed that pharmacists should provide support and guidance to ensure Facilities meet the medicine management expectations under the Health and Disability Services Standards (Figure 12).

"Pharmacists can advise but should not be put in a position to enforce or be held accountable for compliance" – (Pharmacist)

Figure 12: Proportion of respondents who agreed that pharmacists should provide support and guidance to ensure Facilities meet the medicine management expectations under the Health and Disability Services Standards (n=67)



Respondents were generally supportive of having pharmacists provide advice and guidance to ensure Facilities meet the medicine management expectations under the Health & Disability Services Standards. However, the respondents were strongly against having pharmacists enforce compliance but agreed that pharmacists had a role to play in this area.

Although facilities were already audited regularly by the Ministry of Health, respondents welcomed regular visits from pharmacists to check against the standards and to keep facilities updated on any changes. Other areas of focus that were raised include:

- Control drug register checks
- Fridge temperature checks
- Pre-audit checks
- Contraindication review
- Medication reconciliation
- Medication management competencies
- Check expiry of medicines
- Advice on new medications and brand substitutions
- Regular bulk supply orders
- Medication expiry
- High-risk medicines ie narrow therapeutic index
- Safe storage of medicines
- Medication efficacy
- Development of management systems for safe management of medicines
- Medicine information services

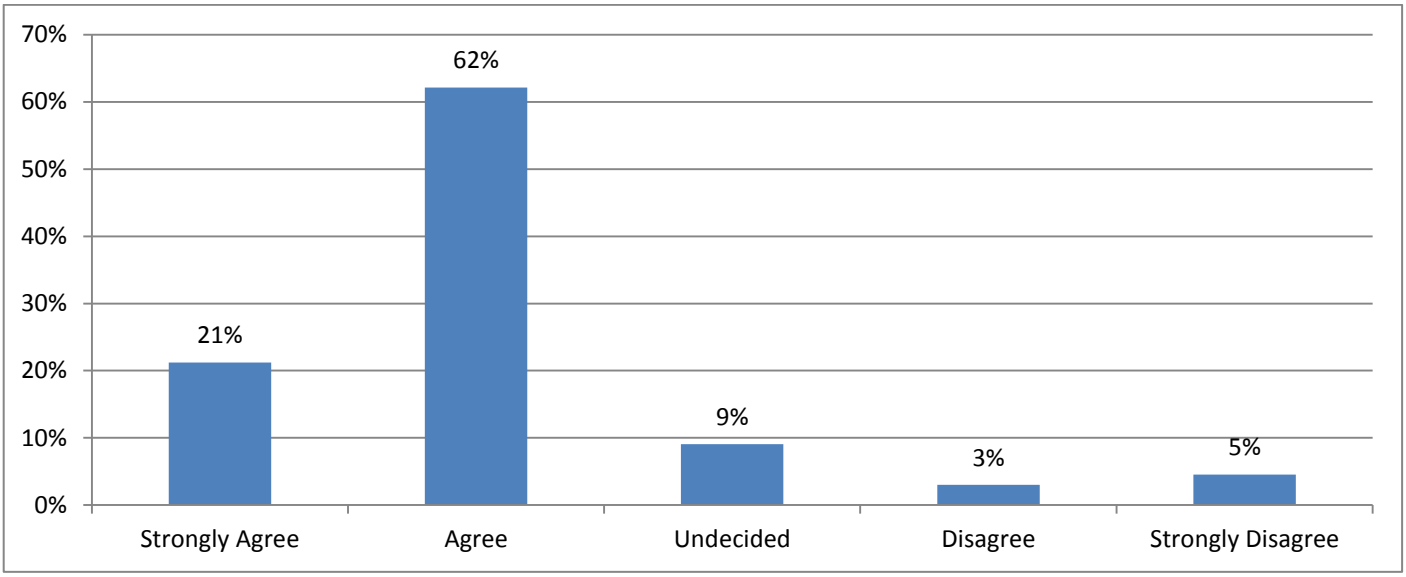
Service Component 4: Performance framework & monitoring

Under the proposed model, the DHBs will develop a performance framework to ensure that a mechanism is in place to monitor service delivery. This will allow DHB Funders and service providers to continuously improve the service over time. The proposed performance framework will also support improved data gathering to determine future areas of focus. A selection of process and outcome measures will be reviewed on a regular basis, for example, patient and staff satisfaction, hospitalisation rates subsequent to receiving the service, and reduction in the number of regular medicines prescribed.

83% of respondents agreed that a performance framework should be formed to inform continuous improvement of service delivery for pharmacies over time (Figure 13)**.**

"The development of a performance framework and specific indicators needs to be a joint exercise but one that will inform future commissioning of care." – (Pharmacist)

Figure 13: Proportion of respondents who agreed that a performance framework should be formed to inform continuous improvement of service delivery for pharmacies over time (n=66)



A majority of respondents agreed on the need for a performance framework to inform continuous improvement. The key requirement from respondents is that DHBs work with the sector and sector representatives to develop the framework and specific performance indicators that are easy to measure. Furthermore, the framework should be related to specific indicators that can be influenced by the pharmacy provider.

> *"I think a standardised performance framework will likely be of benefit but the standard of service needs to be more clearly understood and defined by the DHBs before being linked to such a framework." – (Pharmacist)*

A few respondents suggested a transparent process to address performance issues and wanted the DHBs to take appropriate action to address poor performance. Respondents also indicated the importance of having a feedback mechanism for system glitches and escalation processes.

> *"A feedback mechanism also needs to be established so that on the ground workers can feedback about glitches in the systems and of course there must be a timely collation of any problems and a pathway to remedy them." – (Other healthcare professional/provider)*

Respondents provided the following as indicators or measures that should be considered in the performance framework for pharmacy providers:

- Hospital admissions
- Medication adherence incidents
- Frequency of chart changes
- Medication waste
- Facility staff satisfaction
- Resident satisfaction
- Delivery time
- Dispensing errors
- Imprest stock checks
- Audit criteria (HDSS)
- Number of residents
- Prescriber feedback
- Number of medication reviews
- Number of review recommendations
- Number of recommendations implemented
- Number of after-hours medication requests
- Polypharmacy
- Number of education sessions

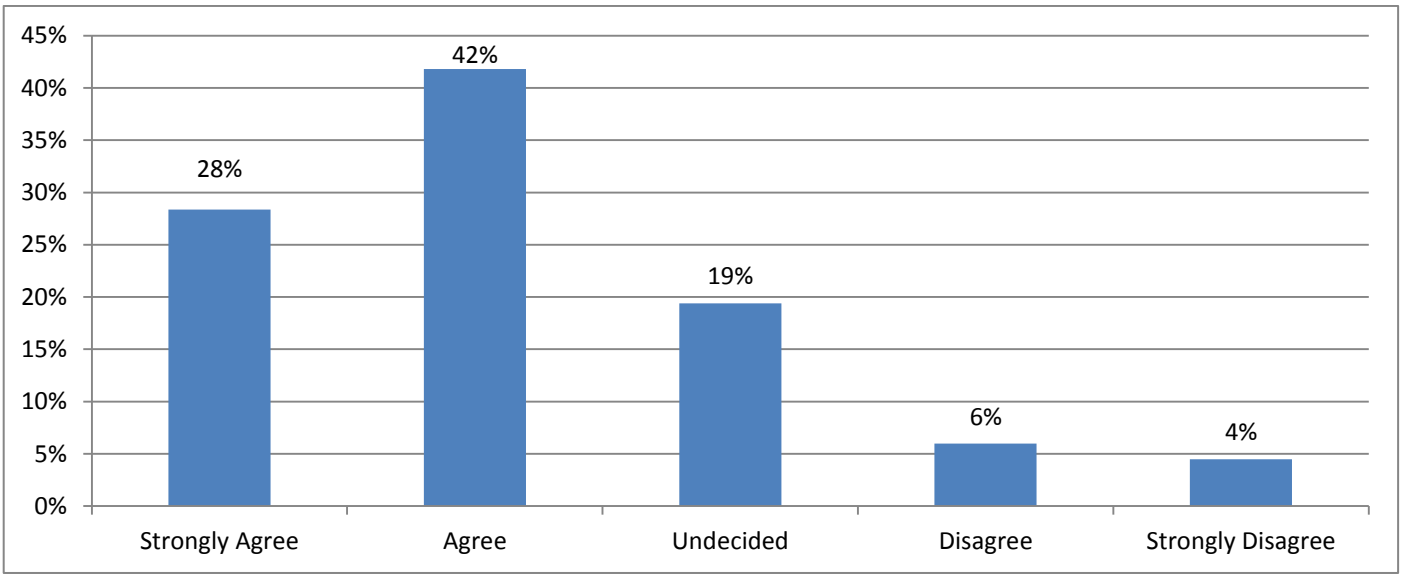
Respondents provided the following as specific areas for quality improvement where pharmacist input will be useful:

- Regular assessment of medicine administration
- Investigate incidents and adverse effects
- Closer working relationship with ARRC and CRC facility managers
- De-prescribing / polypharmacy reduction
- Dialogue and feedback with prescribers on medication issues
- Medicines optimisation to support falls prevention

70% of respondents agreed that pharmacists are well placed to conduct investigations into dispensing and/or administration processes/errors, and to work with Facilities on how improvements can be made (Figure 14)**.**

"Pharmacists are at the forefront of dispensing and would be well positioned to make changes in processes to ensure errors are nullified. This experience can be carried over to administration processes, where recommendations can be made to improve processes." - Pharmacist

Figure 14: Proportion of respondents who agreed that pharmacists are well placed to conduct investigations into dispensing and/or administration processes/errors, and to work with Facilities on how improvements can be made (n=67)



Although the majority of respondents agreed that pharmacists are well placed to conduct investigations into dispensing or administration processes, some respondents were concerned about the capability and knowledge of pharmacists in these specific areas. Respondents also felt that pharmacists can only provide advice and suggestions for improvement, but cannot dictate how Facilities operate. Furthermore, respondents felt that time constraint is a key barrier and that pharmacists are not on-site regularly enough to have active involvement in investigations.

Financial impact: Consistent pricing for all Facilities in the Metro Auckland region

Larger residential care providers are able to negotiate better pricing and services from pharmacies than smaller residential care providers. The proposed service model aims to ensure a consistent service and pricing for all Facilities in the Metro Auckland region. Our desire is to offer the enhanced residential care pharmacy services at no costs to patients and Facilities. However, in an event where this outcome is not achieved, the only fees payable by residential care will be the Government prescription co-payments (and exemptions will apply when residents are dispensed over 20 items of medicines). Therefore, respondents were asked to comment on the financial impact if the proposed service model resulted in the usual Government prescription co-payment being applied to all residents.

Respondents had mixed views on the pharmacy services being delivered at no cost to residents and Facilities. Some community pharmacies are currently providing a free service to residents and Facilities. This means that the pharmacy has decided not to charge the standard prescription co-payment, adherence packaging fee, delivery fee or medication reviews. Therefore, Facilities and residents who receive the service for free may be negatively impacted if costs rise due to the proposed model. Some respondents have negotiated competitive pricing with their pharmacy provider and see benefits of a free competitive market.

> *"The costs we [Facility] incur currently from the pharmacy we use are acceptable and the support is real value for money. There is significant and irreplaceable value in having a pharmacist who has sound and continuing knowledge of our residents, our GP and our facility" – (ARRC facility owner/manager, Registered nurse)*

There are some respondents who suggest that the impact of the proposed model will have minimal impacts to residents and Facilities because the prescription co-payments are fees that ARRC providers are required to pay under the national ARRC Services Agreement. These respondents were more concerned about the variable fees with adherence packaging and the risk that costs for non-subsidised medicines will be inflated. Respondents mentioned that pharmacies may apply additional fees to cover the cost of delivering a more comprehensive service.

Respondents suggested that the DHBs should consider the wider government policy objectives around prescription co-payments for the specific patient groups. A small group of respondents felt that the discounting of prescription co-payments is only sustainable for large pharmacy providers and is putting pressure on small to medium pharmacy providers.

Gaps in the proposal

Respondents were asked if there were any gaps in the proposed model that the DHBs have not considered or areas that they did not understand.

53% of respondents said that there were gaps in the proposed model (n=118).

"There is no concrete evidence that the approach is going to be viable and work with all parties." - Pharmacist

The main themes identified from respondents who said there were gaps in the proposed model were:

Lack of detail in the proposed model, especially the service specification, funding model and selection process.

> *"There is a lot more detail required in the DHB proposal. It lacks detail on procurement, service design, implementation, funding impacts, and any impact analysis on providers and service users. Community Pharmacy needs to be directly involved in developing the proposal. I am concerned about the mitigation of risk and commercial impact on my Pharmacy, when we are already offering a high level of service with young pharmacists operating at the top of their scope." – (Pharmacist)*

> *"The transparency of the selection process so applicant pharmacies can be sure their applications have been reviewed fairly, and decisions are made on totally objective grounds" – (Pharmacy sector representative)*

Contractual issues

Implications on the Integrated Community Pharmacy Services Agreement

> *"It is unclear whether the proposal would be implemented as a variation of the current ARRC or CRC schedules, or be introduced as a new service specification. The proposal is also not clear whether, in DHBs view, providers can choose to stay on their current specifications if a new service specification is introduced, as per the voluntary variation clauses in the ICPSA." – (Pharmacy sector representative)*

Implications on existing contractual arrangements between pharmacies and Facilities

> *"Metro Auckland DHBs' proposal should consider the legal implications of existing contracts between community pharmacies and facilities." – (Pharmacy sector representative)*

Lack of alternative models that supports improved medicines management

Financial viability for pharmacies

Some respondents expressed their concerns about the financial viability of the pharmacy sector if a limited number of pharmacies were selected with exclusivity to offer the service.

> *A lot of pharmacies have already invested in automated technology and additional pharmacist staff to service their facilities so potentially there could be staff layoffs and a lot of pharmacies with expensive technology being underutilised. Also this could severely impact on a lot of pharmacies financially. – (Pharmacist)*

Common Themes

There is general agreement that the four broad service components proposed are appropriate pharmacy services for residents living in ARRC and CRC Facilities. The majority of respondents agreed on the overall elements of the model which includes a holistic patient-centred medication review, utilisation of electronic charting and further pharmacist input in health information and education.

> ***"The proposed service model I believe is a step in the right direction. It will help improve processes with the use of automation/robotics, it will provide residential care facilities with a higher quality service, and will strengthen the collaboration between healthcare professionals. Ultimately leading to better patient outcome, which should always be at the forefront of what we do." - (Community pharmacist)***

Respondents provided a wealth of insights and there were reoccurring concerns mentioned throughout the feedback. The main concerns raised are grouped into the following categories:

1. The current pharmacy service provision is satisfactory

Some respondents expressed that they already receive the proposed service components and that pharmacies are delivering excellent services to these facilities. In addition, they further questioned that the current service was variable and required changes to further improve it.

A number of respondents highlighted the importance of having a well-developed relationship with the resident and having an integrated care team that includes the pharmacist. Therefore, some Facilities were concerned that the relationship with their existing pharmacy provider would be damaged if the pharmacy was unable to continue providing services as a result of this proposal.

> *"The risk of losing an excellent arrangement for which we have certainty, with a big bold new idea which may have teething difficulties and prove to be disappointing overall - the risks of trying to fix something which is not broken in the hope that budgets can be tightened." – (General practitioner)*

In contrast, there were some respondents, who also suggested that there were no risks with the proposed model as long as the newly selected pharmacies have the capability, capacity and reputation in delivering high standards of service.

> *"I don't see any risks with this model. Providers must always have the autonomy and choice of their preferred supplier, someone who has been servicing them for years and had established good working relationship without clinical issues." – (ARRC facility owner/manager)*

2. Concerns about the limited number of pharmacy providers

Many respondents highlighted risks with limiting the number of pharmacy providers with exclusivity to deliver pharmacy services to ARRC and CRC facilities. Their primary concern is that Facilities will not have the autonomy to select their preferred pharmacy provider and the risk that their current pharmacy provider may not be awarded a contract by the DHB. Furthermore, respondents also expressed concerns that the DHBs' intention to select a small number of large-scale pharmacy providers may reduce timely access to urgent deliveries and service quality.

> *"If you limit the service providers then you remove our right [of] choice. These [pharmacy] providers may be some distance from the facility thus then possibly impact on our urgent delivery requirements." – (ARRC facility owner/manager)*

"I agree a more specialised service should provide safer patient care, and prevent over medicating, but limiting the number of service providers takes away the good relations with local pharmacies, creates monopolies and takes away choice and flexibility. Auckland City is too widespread and traffic challenges make the proposal as per the questions above difficult to respond to sudden changing needs of patients, and lead to missed medications and waste in the long run." – (Registered Nurse)

In addition to the above responses, the ARRC facility/manager respondents had concerns that the standardisation of pharmacy services, along with limiting the number of pharmacy providers will result in non-personalised services being delivered to residents and Facilities. They emphasized the importance of having pharmacy services that are flexible and providers who are adaptable to meet the individual needs of residents and Facilities. Furthermore, this flexibility is required in the service offering for different types of facilities (ie ARRC vs CRC facilities, large vs small facilities, and rest-home level care vs hospital level care).

"The facility should be able to seek proposals from and utilise any pharmacy it chooses in a free market, and each facility may have individual needs and priorities that are not able to be met by a blanket forced arrangement that selects for large chain providers and a rigid framework." – (ARRC facility owner/manager)

"The risk of circumventing a free market and that the criteria in which pharmacies are chosen not taking into account the individual needs of a facility. Facilities operate in different ways to meet the needs of different residents. Taking away choice of service suppliers reduces individuality of facilities and reduces the ability to cater for niche needs and having an individual "flavour". – (ARRC facility owner/manager)

Respondents had concerns that limiting the number of pharmacy providers would reduce competition between pharmacies and create a monopoly within the system. Respondents also questioned how the DHBs will manage new entrants into the market and risk mitigation strategies during unforeseen circumstances (ie natural disaster, power outages) in an environment with a limited number of pharmacy providers.

"[The risk is] Monopolistic behaviour from large service providers that would leave rest homes without effective provider choice, and diminish innovation through degradation of competition." – (Pharmacy sector representative)

"Facilities need to be able to have choice in [pharmacy] providers. If they receive a level of service which is unacceptable, they need to able to change. [DHBs] Cannot bind a facility to 1 or 2 pharmacies. Exclusivity will lead to the bare minimum being provided as pharmacies will know the facility is stuck with them, stifling innovation and competition. Rather than having exclusive pharmacies, we should have standards for pharmacies to be able to provide ARRC services. As long as they meet those criteria, they should receive a contract." – (Pharmacist)

3. The level of funding to deliver the proposed model may not be sufficient

Respondents had raised concerns about the level of funding required to deliver the proposed service components. It was highlighted that medication reviews and training sessions take a considerable amount of time and pharmacists will need to be reimbursed fairly for the work. Furthermore, other health professionals in the care team (ie prescriber, nursing staff) may be negatively impacted due to the set up of new systems and processes, such as electronic charting). The costs of the proposed service have broader implications, not only within the pharmacy sector, but on other healthcare providers. There are concerns that these costs may be passed onto residents.

"I believe that the proposed service components will be expensive to implement in a truly comprehensive manner. These large dispensing pharmacies will require staff trained in packing medications, a team of clinical pharmacists (they will require further qualifications/training to be able to undertake medication reviews - courses provided by the Pharmaceutical Society in MUR have not had a great uptake predominately, I feel, because the services have rarely been funded sufficiently to make it worthwhile so I urge you to ensure realistic funding is considered to achieve this service) and staff available to transport medications to their destination whenever required." – (Other: Hospice clinical pharmacist)

4. Change management and implementation

Some respondents had concerns about the implementation of the proposed service model and the risk mitigation plans to ensure patient safety is not compromised. Respondents highlighted the importance of engagement with all relevant providers who may be impacted by the proposed change.

"A plan for incrementally implementing the model that recognises the need for staged change to allow the development of resources, training of staff needed for the full implementation of the model and recognises service implementation will need to be based on adapting existing tools, and processes rather than replacing them with totally new processes, and tools." – (Pharmacy sector representative)

Change management is a significant risk area to residents. A change in process (eg operating procedures and change to electronic charting) or a change of provider will present a window where medicine errors could be made. This is unavoidable due to the complexity of change and must be factored into DHB's impact analysis and implementation plans. – (Pharmacist)

Next Steps

The consultation summary report will be presented to the Boards of Auckland, Counties Manukau and Waitemata DHBs. The Boards will review the findings and take into consideration the concerns raised by respondents.

There are a number of concerns relating to the implementation of the proposed model and this requires additional planning and coordination by DHBs, in partnership with key stakeholders. The DHBs intend to evaluate these concerns in more detail and will communicate with stakeholders once a decision is finalised by the Boards on a way forward.

Appendix 1: Schedule of meetings

What did we do	When
Auckland DHB ARC Steering Group	Tuesday 2 October 2018
Residential Aged Care Integration Programme (RACIP) meeting	Tuesday 9 October 2018
HOPs Stakeholder Group (incl Aged Concern, Grey Power)	Thursday 11 October 2018
Public evening session - Waitemata DHB	Monday 15 October 2018
Public evening session - Auckland DHB	Tuesday 16 October 2018
Health Link North Board meeting	Wednesday 17 October
Health Link Board Meeting (Waitakere)	Friday 19 October
Waitemata DHB ARC Provider Forum	Friday 26 October
Public evening session - Counties Manukau DHB	Monday 19 November 2018
The Asian Network Inc	Wed 21 November

Appendix 2: Organisations/businesses who responded

- Unichem Kelston Medical Pharmacy
- Dominion Road Pharmacy
- ProCare
- Caliburn Medical Services Ltd
- Rescare Homes Trust
- Care Home / BUPA
- Concord House Rest Home
- Mary MacKillop Care
- Te Roopu Taurima
- Remuera Rest Home & Hospital
- Papakura Private Hospital
- Care Alliance 2016 Ltd
- Emerge Aotearoa (NGO)
- Tui House
- Westmere Pharmacy
- Waitakere Health Link
- Residential Rehab Facility
- Waimarie Private Hospital
- Patrick Ferry House & Terence Kennedy House
- SOLEMAR (Aged Care)
- Gulf Views Rest Home
- IDEA Services West Central Auckland
- Care Association NZ
- Nirvana Pharmacy Group
- Sylvia Park Rest Home & Hospital
- Lexall Care
- Grey Power
- Chemist Warehouse
- Hobsonville Pharmacy
- Pakuranga Pharmacy Limited
- Unichem Golf Road Pharmacy
  Pharmacies
- ZOOM Pharmacy
- IDEA Services
- Summerset
- Unichem West City Pharmacy
- Douglas Pharmaceuticals Ltd
- Home and Community Health Association
- Green Cross Health
- Anne Maree Group Rest Home & Hospital
- Medi-Map (Medicines Management Software
  Provider)
- Pharmacy Guild NZ
- Pharmaceutical Society of NZ
- Waitemata DHB Inpatient Pharmacy Services
- St Andrews Village
- Ryman Healthcare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