DHBs’ Consultation – Delivering on the Pharmacy Action Plan
Workshop with New Zealand Young Pharmacists Group

Wednesday 4 April 2018
TAS, Tory Street

Whiteboard notes

What opportunities do you see in the Pharmacy Action Plan and proposed new contract?

1. To move out of community pharmacy, more opportunity to practise in advanced roles
2. More opportunity to practice in advanced roles
3. Pharmacist specialisations – fund the training!
4. To not be considered as an allied health professional
5. To be contracted based on disease-specific issues
6. To purchase specific models of care
7. Patient continued care
8. Division is good for MUR, MTA etc, if fairly paid and risk assessed.

Questions and concerns

1. How do we get there? – funding, MUR, MTA, jobs?
2. Roles – what are they, how do we qualify?
3. How do we take advantage of doing these services (3B) – DHB, PHO being on board
4. Who gets the opportunity to deliver these services within community pharmacy
5. Workforce development for future services as a risk – cost?
6. If you’re going to allow pharmacists to offer new services, which pharmacists and why?
7. Schedule 1 and 2 split: what will it mean for service delivery and the delivery of medicines and care
8. How is the auditing process going to work?
9. Who will be responsible for audits?

10. Funding for post graduate training – who would fund this?

11. How would you ‘prove’ the counselling services?

12. How are we to receiving funding for OTC services, health navigators, or services that patients can go to the supermarket, etc for?

13. Why should opportunities for funding be linked to pharmacies?

14. Will this provide opportunities for pharmacists to take up PHC/primary care roles of doctors?

15. What is the motivation for splitting the schedule in two?

16. Will non-pharmacists be able to access IPSC contract funding?

17. How will this free up pharmacists to provide other services?

18. With the introduction of 3B & C, will this mean that pharmacists need to do more training?

19. What does evergreen mean going forward, how much can it change without future negotiation? Not tested? – how much negotiating power do we actually have?

20. This is decrease in dispensing fee with the split – how will businesses be sustainable and safe?

21. Where is the detail?

22. CPI adjusted? Cost pressure adjustments – including for APC other pharmacist costs

23. Going forward with changes in dispensing structure (for example robotic dispensing) what is the likely change in the balance of funding between Schedule 1 and 2?

24. How do we capture the swings and roundabouts of patient care, for example when patients can’t pay for their medicines, fax fees, etc? Why should the pharmacy pay for the costs of care of patients who can’t afford their medicines?

25. What further services can pharmacists do?

26. How do we integrate and what does it mean? Who is the leader of the team, where do the resources come from?

27. Should there be funding for the coordinating care role of patients?

28. Targeted services – where is that money coming from? Out of the current pool?
“New money” – how do we get it – how do we lose it?

Pilot – who gives this input for us to do a pilot?

Who pays for the pilot?

Trust – works both ways – LTC – we aren’t trusted!

New pharmacy license – just handing them out?

Why rush – no data to support

This is similar to LTC....

Strikes – safety blanket for pharmacist

Why issue more licenses? Change legislation?

What roles / work could you see pharmacists having in the future?

1. More home visits for patients that would benefit from them, eg LTC
2. Multi-disciplinary approach / smarter ways to approach patients
3. A way to engage with patients who aren’t coming to you
4. Virtual consultations
5. MUR/MTA
6. Integrated services (preventative medicine) – pharmacies, health sector
7. Individual contracts with individual pharmacists
8. Health checks
9. Consultation and follow up for continuity of care for LTC patients
10. Prescribing for continuity of care/patient care directives

Limitations:

1. How do we free pharmacists – PACT (regulations) – pharmacist facilitator – mental health community - advises on RX
2. Space (physical barrier)
3. Money
Direction of funding (area specific vs person specific)

Reactive profession, eg reliant on RX from doctors without access to full patient notes

Barriers = health information

Period of supply

Doctor / pharmacist relationship

Mitigations:

1. DHB to understand difference between LTC, MUR, MTA, etc
2. Integrated health information
3. Increased access to information and communication with the prescriber

How do you see this could impact you in the future?

1. More services – eg nicotine all DHB funded the same per consult
2. In communities eg home visits, marae, GPs – who will dispense / pay $$ in pharmacy??
3. Mental health counselling
4. Paid for prescription corrects / GP questions
5. Share care / e-prescribing paid
6. Integrated services – paid to consult other professionals

How do you see this could impact you in the future – impact on job security / how will my day be spent/fees/study?

1. Training requirements – funding is low, will we all have the same uni training? Extra study?
2. Is the economic status of the DHB going to affect whether I get the funding or not
3. Unknown worry:
   – want to see investment into the profession and this contract suggestions (financially)
   – options for the day-to-day role carries risks
4. More receptive to ideas with a clear outcome for example vaccines – prescribing harder to see.
5 Why can we not pilot this in one DHB first? – has this been done around the world before? A lot of other models accept robotics (automation) for what is proposed in Schedule 1.

6 Majority of our funding comes from our base services (dispensing) if you take that away from us, how do we know you won’t take away ‘funding’ for other services?

7 Support from colleagues is missing – for example GPs, nurses, CPAMs (integration)

8 Ethical implications - If your contract is for only Schedule 1 but your patient wants advice that you know you can give, what are you meant to do? Most pharmacies would still give the advice because best for patient.

9 Mobile pharmacists – travel – safety into places not comfortable in.

10 Pharmacies in isolation – rural - communities with one pharmacist

11 Trust – does the contract go to the pharmacies or the ‘pharmacist’? Word ‘pharmacist’ used in the title.

12 Expanding is exciting – one on one time with patient – patient centred care

13 Where does this role fit in – roles need to be defined

14 New roles create potential and career progression but when we ask what this looks like there is uncertainty – instils uncertainty in us

15 Processes to get remuneration – reporting processes are unattractive

16 Job security risk – the opportunities that the pharmacies provide will be based on the revenue that the pharmacy brings in without knowing what to plan for, how do we have any confidence or comment on job security? – clarity (black and white), figures

17 Patient risk – are we spreading ourselves too thin across these services?

Whiteboard summary (top 3 thoughts from each table)

- Clarity of funding:
  - Opportunity based on revenue – how to plan without clear revenue streams is difficult
  - DHBs to invest in pharmacists to give advice and keep core funding stable

- DHBs purchase models of care:
  - Opportunities for patients and for pharmacists
  - Engaging with patients who aren’t engaged / MUR / less dispensing
  - Evaluation of any new services needs to be built into design

- Policy:
  - Address contradictions re: licensing / contracting – letting any pharmacy get a contract
  - Addressing regulation/limitations

- Contract:
  - Pharmacist facilitating / working with other health professionals and/or in other settings
  - Schedules 1 & 2 need back to back agreements
• Strategy & engagement
  o Representation on Alliance groups – pharmacy owner and pharmacist
  o Governance for new contract – need pharmacist voice
  o Timing – readiness
  o How do people move in the same direction
  o How do people have the conversations
• Trust
• Transparency

Questions from NZYPG members answered by DHB representatives at the workshop

1. Trust - How do we take a risk and put trust into MoH and DHs when it has not proven to be beneficial before? “I was explicitly told in a DHB meeting that many pharmacies should be shut down and not exist and that the contract can be used as a control mechanism with as much as 40% going to local commissioning”
  • Currently, 70% of funding sits within the core pharmacy services – Schedules 1 and 2 i.e. dispensing and 30% is in Schedule 3 – locally commissioned services. That might be where the 40% number came from. There are over 100 services that local DHBs fund outside the core services. In terms of the Schedule 3 services, DHBs can choose to retain the current services – they won’t simply disappear. However, if DHBs want to modify the current services, the proposed contract outlines a process for doing that which DHBs must follow.
  • Trust is a common theme brought up at the road show meetings up to the local level and local DHBs. There are many DHBs around the country where they have a good trusting relationship with their pharmacists e.g. CDHB. But we do recognise there are some DHBs that have this issue. This is an opportunity to build / rebuild trusted relationships locally between pharmacists and DHBs. Trust issues are needed to be addressed by both parties.
  • In the contract, there are change control mechanisms so DHB’s have to work at a national and local level
  • Both parties need to agree
  • There is no agenda to shut down pharmacies. DHBs need a sustainable and viable pharmacy sector to deliver services to their populations, but aren’t responsible for individual businesses
  • There are 150 pharmacies around the country that due to their geographical location if they shut down, it would make it more difficult for people to access services, they are essential.

2. Patient impact- has there been a risk impact analysis created for our patients? How will this affect them?
  • DHBs want high quality services delivered to their populations
  • From Day 1 there are no changes
  • As new services come about, and business cases are developed, health outcome measures will be expected to be looked at and this included
  • Schedule 1 and Schedule 2 split- working with Pharmacy Council and other key stakeholders to make sure patient safety is not compromised.
• Next step - would be a very wide consultation and will look at where emphasis needs to be which is important for risk assessment

3. Am I going to be fighting with other professions for what I’ve always believed was a pharmacist’s role?

• Pharmacist need to be involved at the systems level - this requires a proactive approach by pharmacists

• Currently there is a review of funding of residential care – and medicines management is included in the terms of reference. There are examples of pharmacists leading or being involved in innovative or new roles in these 100 extra services or via alliances where they would not have been before.

• These things take time – need to shift people’s thinking to understand pharmacy is an integral part of healthcare team. This is a slow step. If pharmacists continue to just dispense medications, this will not change.