Capital & Coast
District Health Board
ŪPOKO KI TE URU HAUORA

Meeting Minutes

PHARMACY SERVICE DEVELOPMENT REFERENCE GROUP MEETING

Date and time of Meeting:	2/02/06 11.00am – 1.00pm
Purpose of Meeting:	Pharmacy Service Development Reference Group
Place of meeting:	Te Taha Wairua Level 1, Lotteries Building Cambridge Terrace Wellington
Invited Attendees:	Jane Caldwell, Ann Privett, Mike Seymour, Matt Tyson, David Mitchell, Dianne Harries, Julie Yee, Geoff Savell, Tim Maling, John Dunlop, Justine Thorpe, Marilyn Tucker, Lee Pearce, Carolyn Rhodes, Frances Acey, Lorraine Offord, Michael Rains, Win Bennett, Sandra Williams, Sue Scott, Pam Bremford, Jan Clare, Kas Govind, Susan Rawlins, David Bratt, Fran Cook

Agenda

1. Welcome.
2. Apologies
3. Minutes of last meeting
4. Matters arising
5. Pharmacy page on C&C DHB Internet
6. Process Mapping Exercise (summary attached)
7. Summary of C&C DHB Pharmacy Pilots (to be provided before the meeting)
8. Discussion paper on future community and primary care services in C&C DHB (to be provided before the meeting)

9. Next meeting

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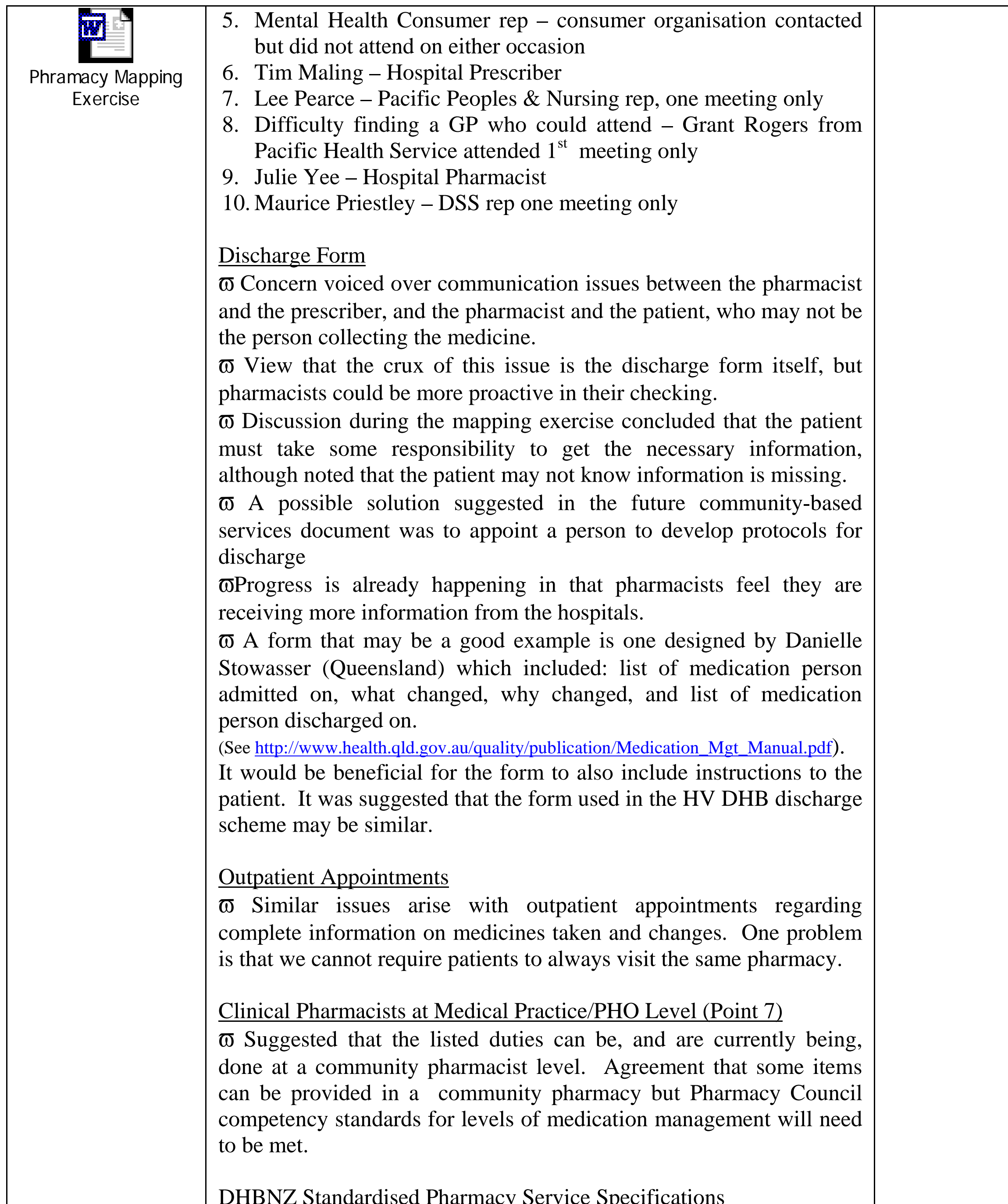
Meeting Minutes

Agenda Item	Discussion	ACTION
1. Welcome	Member attending their first meeting: David Bratt – Primary Care Advisor, GP Liaison, C&C DHB	
2. Apologies	Mike Seymour, Geoff Savell, Lorraine Offord, Jan Clare, Kas Govind, Pam Bremford, Win Bennett, Carolyn Rhodes, Lee Pearce, Justine Thorpe, Jane Caldwell, Julie Yee, Sheryl Williams	
3. Minutes of Last Meeting	Minutes from 9 November 2005 accepted as true record. Action Points: - Frances feels the discharge management issue is still not resolved -Summary of the 4 pilots was circulated as requested. -Information for accessing the Care Coordination Centre (CCC) is being worked on – good, clear information will be on the new C&C DHB website when it goes live week of 6/2 *(now 13/2)*. In the interim GPs and providers all have the CCC details. - Process Mapping Working Party held 2 meetings, summary of this was circulated. - HV DHB discharge scheme: notes in discussion document on future pharmacy services - So far no Community Pharmacy Reference Group meeting has been organised, but will be organised as necessary.	
4. Matters Arising	No matters arising	
5. Pharmacy Page on C&C DHB Website	ϖ Until now, the website link for pharmacy led only to the Pharmacy Services Agreement. The Steering Group agreed that there needed to be more information available online including these meeting minutes. A 'cover page' of links has been put together so that it is clear to people what they are accessing. The revamped website is ready to go live. ϖ All community pharmacists will be able to get information from the site. There is concern that other pharmacists are not giving feedback to the pharmacist representatives that attend these meetings – worry that they will say they were not consulted. The agenda for this meeting was emailed to all C&C DHB pharmacies with the option for people to reply if they wanted papers sent. There was no response. ϖ Suggested that to improve this, the Pharmaceutical Society's email list could be used instead, as it includes all pharmacists. A further suggestion that fax works better than email as it is more accessible for pharmacists in the workplace.	Look at how we send info to pharmacies and pharmacists
6. Process Mapping Exercise	The working party consisted of: 1. John Dunlop – PHO Pharmacist rep 2. Fran Cook – CCC rep 1st meeting only 3. Jeff Savell 1st meeting Sheryl Williams 2nd meeting – Community Pharmacist rep 4. Lorraine Offord & Francis Acey – Consumer reps	



Phramacy Mapping Exercise

5. Mental Health Consumer rep – consumer organisation contacted but did not attend on either occasion
6. Tim Maling – Hospital Prescriber
7. Lee Pearce – Pacific Peoples & Nursing rep, one meeting only
8. Difficulty finding a GP who could attend – Grant Rogers from Pacific Health Service attended 1st meeting only
9. Julie Yee – Hospital Pharmacist
10. Maurice Priestley – DSS rep one meeting only

Discharge Form

- Concern voiced over communication issues between the pharmacist and the prescriber, and the pharmacist and the patient, who may not be the person collecting the medicine.
- View that the crux of this issue is the discharge form itself, but pharmacists could be more proactive in their checking.
- Discussion during the mapping exercise concluded that the patient must take some responsibility to get the necessary information, although noted that the patient may not know information is missing.
- A possible solution suggested in the future community-based services document was to appoint a person to develop protocols for discharge
- Progress is already happening in that pharmacists feel they are receiving more information from the hospitals.
- A form that may be a good example is one designed by Danielle Stowasser (Queensland) which included: list of medication person admitted on, what changed, why changed, and list of medication person discharged on.

(See http://www.health.qld.gov.au/quality/publication/Medication_Mgt_Manual.pdf).

It would be beneficial for the form to also include instructions to the patient. It was suggested that the form used in the HV DHB discharge scheme may be similar.

Outpatient Appointments

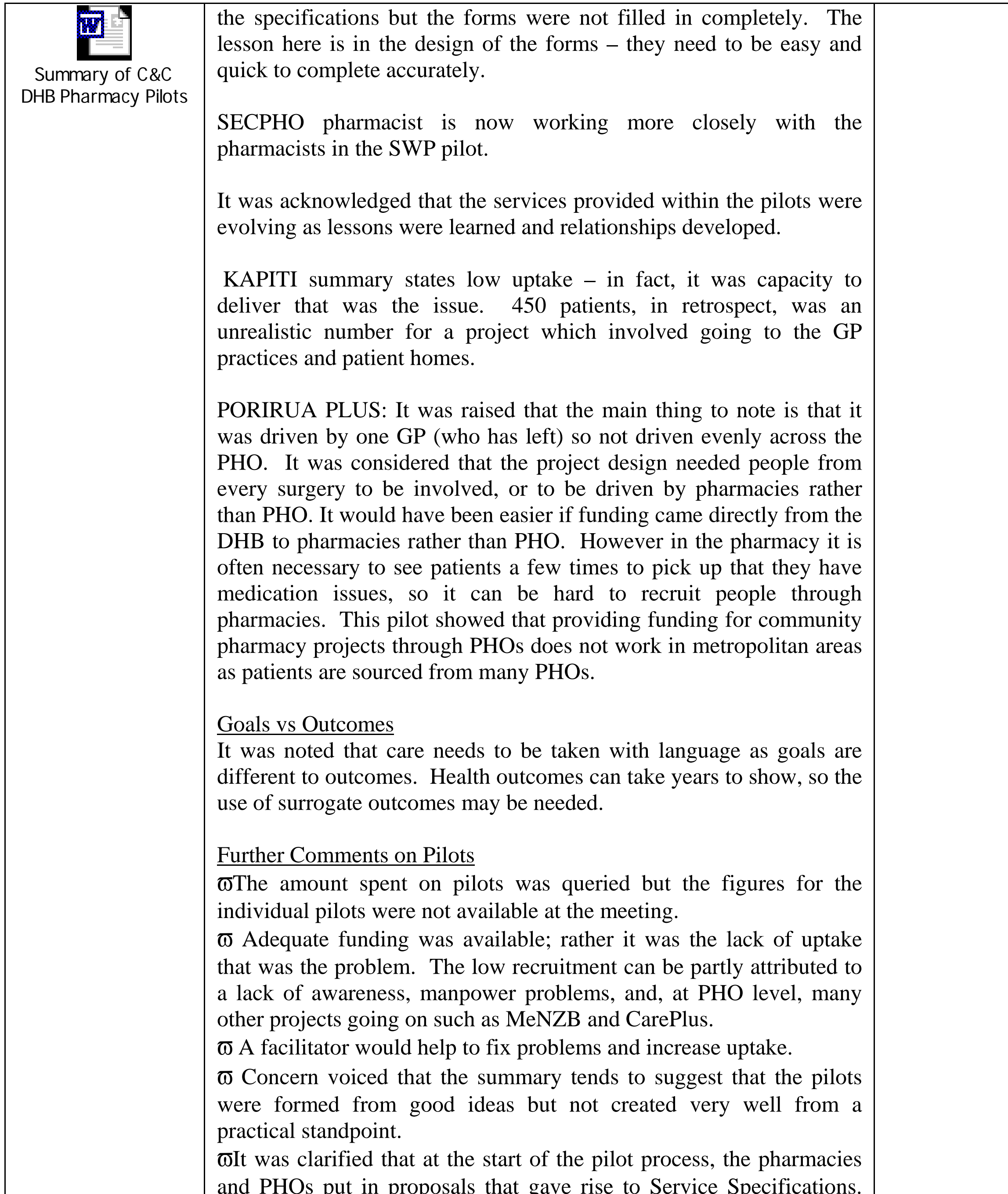
- Similar issues arise with outpatient appointments regarding complete information on medicines taken and changes. One problem is that we cannot require patients to always visit the same pharmacy.

Clinical Pharmacists at Medical Practice/PHO Level (Point 7)

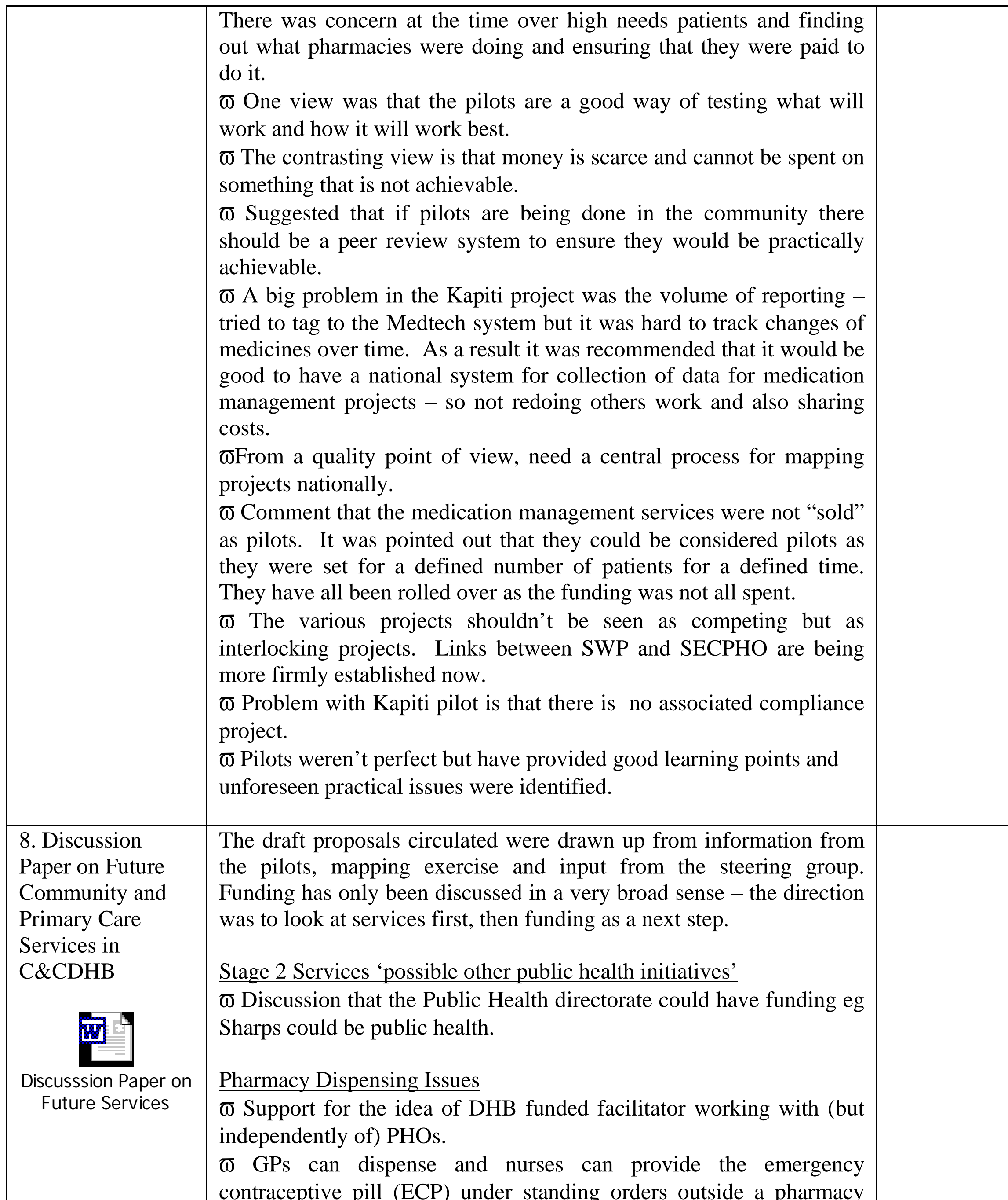
- Suggested that the listed duties can be, and are currently being, done at a community pharmacist level. Agreement that some items can be provided in a community pharmacy but Pharmacy Council competency standards for levels of medication management will need to be met.

DHBNZ Standardised Pharmacy Service Specifications

	ϖ C&C DHB is following the development of standardised service specifications for pharmacy services by DHBNZ. Patient Registration with Pharmacies ϖThis would alleviate problems of incomplete medication records. However, currently patients are often not registered with a single GP or a practice and receive continuation of care at prescriber level. As more professionals become authorised prescribers the situation will get worse Centralised patient record ϖ This is a possible solution to providing all necessary information to prescribers and pharmacists ϖ Enables all authorised people to access the same source of information on a secure intranet. ϖ This would be difficult to set up but is an idea that does need to be looked at further. There is a worry that this issue could grab much focus and money, and thus inhibit other projects. ϖ When looking at taking this forward, must consider the geography of Wellington - would need to talk to HV DHB or look at a national system. ϖ This project would be wider than the electronic health record being developed in the HHS, It would need a complex infrastructure so that many different computer systems could talk to each other. National Provider Identification (NPI) All providers getting NPI issued in March. This is a Ministry of Health project. The NPI will be used on scripts. Pharmacy Licensing – Disability Access Issues ϖ This is already a requirement as in the contract it states that legislation must be complied with. However it may be beneficial to set this out more clearly or have it as a defined item in pharmacy audits. ϖ Point made that disability access should include people such as the deaf and blind. Summary The mapping exercise provided some information for planning future services. It was an atypical mapping exercise in that it found many issues to be addressed rather than identifying more efficient pathways	
7. Summary of C&C DHB Pharmacy Pilots	Points of correction and comments: SOUTH WELLINGTON PHARMACY (SWP) PILOT: Page 7 states that 10% of patients did not meet service specifications. In fact 10% of patients didn't have the criterion reported. The patients did meet	



Summary of C&C DHB Pharmacy Pilots	the specifications but the forms were not filled in completely. The lesson here is in the design of the forms – they need to be easy and quick to complete accurately. SECPHO pharmacist is now working more closely with the pharmacists in the SWP pilot. It was acknowledged that the services provided within the pilots were evolving as lessons were learned and relationships developed. KAPITI summary states low uptake – in fact, it was capacity to deliver that was the issue. 450 patients, in retrospect, was an unrealistic number for a project which involved going to the GP practices and patient homes. PORIRUA PLUS: It was raised that the main thing to note is that it was driven by one GP (who has left) so not driven evenly across the PHO. It was considered that the project design needed people from every surgery to be involved, or to be driven by pharmacies rather than PHO. It would have been easier if funding came directly from the DHB to pharmacies rather than PHO. However in the pharmacy it is often necessary to see patients a few times to pick up that they have medication issues, so it can be hard to recruit people through pharmacies. This pilot showed that providing funding for community pharmacy projects through PHOs does not work in metropolitan areas as patients are sourced from many PHOs. <u>Goals vs Outcomes</u> It was noted that care needs to be taken with language as goals are different to outcomes. Health outcomes can take years to show, so the use of surrogate outcomes may be needed. <u>Further Comments on Pilots</u> ϖThe amount spent on pilots was queried but the figures for the individual pilots were not available at the meeting. ϖ Adequate funding was available; rather it was the lack of uptake that was the problem. The low recruitment can be partly attributed to a lack of awareness, manpower problems, and, at PHO level, many other projects going on such as MeNZB and CarePlus. ϖ A facilitator would help to fix problems and increase uptake. ϖ Concern voiced that the summary tends to suggest that the pilots were formed from good ideas but not created very well from a practical standpoint. ϖIt was clarified that at the start of the pilot process, the pharmacies and PHOs put in proposals that gave rise to Service Specifications.	



	There was concern at the time over high needs patients and finding out what pharmacies were doing and ensuring that they were paid to do it. ϖ One view was that the pilots are a good way of testing what will work and how it will work best. ϖ The contrasting view is that money is scarce and cannot be spent on something that is not achievable. ϖ Suggested that if pilots are being done in the community there should be a peer review system to ensure they would be practically achievable. ϖ A big problem in the Kapiti project was the volume of reporting – tried to tag to the Medtech system but it was hard to track changes of medicines over time. As a result it was recommended that it would be good to have a national system for collection of data for medication management projects – so not redoing others work and also sharing costs. ϖFrom a quality point of view, need a central process for mapping projects nationally. ϖ Comment that the medication management services were not "sold" as pilots. It was pointed out that they could be considered pilots as they were set for a defined number of patients for a defined time. They have all been rolled over as the funding was not all spent. ϖ The various projects shouldn't be seen as competing but as interlocking projects. Links between SWP and SECPHO are being more firmly established now. ϖ Problem with Kapiti pilot is that there is no associated compliance project. ϖ Pilots weren't perfect but have provided good learning points and unforeseen practical issues were identified.	
8. Discussion Paper on Future Community and Primary Care Services in C&CDHB Discusssion Paper on Future Services	The draft proposals circulated were drawn up from information from the pilots, mapping exercise and input from the steering group. Funding has only been discussed in a very broad sense – the direction was to look at services first, then funding as a next step. Stage 2 Services 'possible other public health initiatives' ϖ Discussion that the Public Health directorate could have funding eg Sharps could be public health. Pharmacy Dispensing Issues ϖ Support for the idea of DHB funded facilitator working with (but independently of) PHOs. ϖ GPs can dispense and nurses can provide the emergency contraceptive pill (ECP) under standing orders outside a pharmacy	

	environment however pharmacists cannot. They can only dispense in the pharmacy and must meet all legislative requirements around pharmacies. ϖ A possibility is that a pharmacy could still have the contract but could sub-contract. <u>Compliance Services – Cognitive Input</u> ϖ Services specifications should recognise more complex services with a higher payment <u>Uptake of Compliance Projects</u> ϖMinimum uptake requirement suggested perhaps tied to set-up funding. Further, competence cannot be assured if very low numbers. <u>Palliative Care Services Compliance Management Services</u> ϖ Patients at Mary Potter hospice have been enrolled for medication management in SWP (patients on oral medications rather than pumps). Partners/carers were having great difficulty managing medications, and a weekly or fortnightly unit dose pack helped to sort this out. This shows there is a need for compliance management in palliative care, which could be for a few weeks or a few months. ϖ The Care Coordination Centre has limited involvement in palliative care, however "packages of care" providers are likely to have an active role in medication management. ϖ Queried if nurses assigned to patients could liaise with pharmacy? It is the CCC Care Managers role to have communication with pharmacy. <u>Mental Health</u> ϖ Nothing specifically written about Mental Health in the discussion paper – but will come under disease management. ϖ Working to try to lessen readmission. Medication Management can be a struggle for these patients, compliance packaging could make a big difference. <u>PHO Pharmacist Facilitators</u> ϖ Links between community pharmacists providing compliance reviews and PHO-based pharmacists need to enable patients to be referred in both directions. <u>Subsidy of Medicines</u> ϖ Section 25 as well as section 88 of Health And Disability Act 2000 relates to the subsidy of medicines. <u>Emergency Contraceptive Pill (ECP)</u>	

	ϖ Suggested that more funding needs to be available – some people come in to pharmacies and then struggle with the $30 payment and so don't take it. It needs to be taken within a short time period and so patients cannot wait until they have spare money or can get an appointment with a doctor for subsidised ECP. There was discussion around the possibility of GPs setting a standing order for pharmacists to supply the ECP for free. However, this is problematic as the doctor cannot claim without seeing the patient. Issues with Measuring Health Outcomes ϖ It was suggested that compliance should not be measured as an outcome without also measuring actual health outcomes. Where To Next… It is intended that a paper will go to the Community and Primary Health Advisory Committee (CAPHAC) in mid-March and then the C&C DHB Board. *(This has since been deferred to the 13 April CAPHAC meeting and May Board meeting)* This meeting closed at 1pm	
9. Next Meeting	The next meeting will be on Wednesday 29 March 11am-1pm.	