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Dear Richard,

Integrated Health Care Framework: Pharmacists and doctors working together

Many thanks for the opportunity to comment on the Integrated Health Care Framework for Pharmacists and Doctors, co-developed by the Pharmacy Society of New Zealand (PSNZ) and New Zealand Medical Association (NZMA). It is commendable to see the associations of two health disciplines working closely together and the College supports this partnership.

Introduction to general practice and the College

General practice is the medical specialty that treats patients: with the widest variety of conditions; with the greatest range of severity (from minor to terminal); from the earliest presentation to the end; and with the most inseparable intertwining of the biomedical and the psychosocial. General practitioners (GPs) treat patients of all ages, from neonates to elderly, across the course of their lives.

GPs comprise almost 40 percent of New Zealand's specialist workforce and their professional body, the Royal New Zealand College of General Practitioners (the College), is the largest medical college in the country. The College provides training and ongoing professional development for GPs and rural hospital generalists, and sets standards for general practice. The College has a commitment to embed the three principles (participation, partnership and protection) of Te Tiriti o Waitangi (Treaty of Waitangi) across its work, and to achieving health equity in New Zealand.

Health equity is the absence of avoidable or remediable differences in health outcomes and access to health services among groups of people, whether those groups are defined socially, economically, demographically, or geographically (WHO). To achieve health equity, we advocate for:

- A greater focus on the social determinants of health (including labour, welfare, education, housing, and the environment).
- Funding and support to sustain the development of a GP workforce of sufficient capacity to meet population need for access to quality primary medical care, particularly in rural and high need areas.
- Sustained focus on measures to reduce smoking and to increase healthy food options for low-income families.
- Improved integration of primary, community, and secondary care health and social services which ensures the provision of high quality services.
- Universally accessible free primary health care for children and low-income families, because health inequities begin early and compound over the life course.
- A review of the funding model for primary care to ensure that resourcing is allocated equitably across diverse populations with differing needs.

Submission

The College agrees that integration between healthcare professionals is important to ensure the equitable provision of high quality, patient-centred services. The College acknowledges the considerable skills and knowledge that clinical pharmacists have, and notes its support for their increased integration into multidisciplinary primary care teams.

Overall, the Integrated Health Care Framework for Pharmacists and Doctors (the Framework) document both promotes integrated models for pharmacists and general practitioners and provides a helpful system to consider how this might be achieved. The College congratulates the PSNZ and NZMA on developing the Framework as well as the Template which pulls together a comprehensive suite of elements of integrated care. This template could be adapted and utilised by many other health professions for similar purposes.

1. ***Introduction of Principles*** *(page 5)*

With regards to the comments about 'enhanced pharmacist roles', the College reiterates statements made in it submission on the draft Pharmacy Action Plan (Nov 2015)[1]:

> Increasingly, the expansion of existing roles is suggested as a way to manage current workforce strategies and this trend is reflected in the Plan. While such expansion (e.g. prescribing capability) can have benefits, the College has concerns that – in some situations – it can also have a negative impact on continuity of care, and on the comprehensiveness of primary care.
>
> Patient visits for minor ailments provide useful opportunities to engage with patients on other health issues, and help develop the relationship between a patient and their primary care provider. A good relationship allows for better sharing of information between patient and provider, and enables the practitioner to put symptoms into context (i.e. pattern recognition and collective symptom identification).

Continuous care also means that there is oversight of treatment and consistent advice is being provided. The College is particularly cautious towards the expansion of roles in independent community pharmacies, with no or limited links to the local general practice and a retail focus.

Principles of Integrated Pharmacist – Doctor Care (page 6)

Generally, the College agrees with the principles of integrated pharmacists-doctor care however it is difficult to comment on them as they are not explicitly applied nor explained after their introduction. For example, we are unsure what is meant by the principle, 'Acknowledge the sustainability requirements of each profession'. This could be referring to the increasing capability of dispensing technology and its impact on pharmacist role, the ageing medical workforce, health practitioner geographical distribution, or any number of sustainability issues. It is recommended that further explanation and referral back to these principles is included throughout the document.

Additionally, it is noted that the principles currently have inconsistent syntax; some are statements while others are commands. To enhance communication and understanding of the principles, the College recommends rephrasing the principles to all be statements.

The College also suggests adding a seventh principle: It is the College's position that continuous and comprehensive care is best provided by a collaborating multidisciplinary team of health professional with oversight, delegation and leadership by the patient's usual health provider (normally a GP), and in which team members share access to a common Patient Management System (PMS). Preventing fragmentation of care is of particular importance where multiple healthcare team members are able to prescribe due to the increased risk of polypharmacy, contraindications, and poor health outcomes.

[1] RNZCGP Submission available on the College website's Submissions page under the subtitle Medicines and Prescribing.

We suggest that because the flow of complete patient information between health care professionals is paramount to minimising errors and providing continuous patient care, it is of sufficient importance to be included as an overarching principle. To this end, we recommend that the following additional principle is included:

> "Doctors and pharmacists communicate with each other (and other multidisciplinary team members) and work to ensure continuity of patient care."

2. ***The Integrated Health Care Framework*** *(page 7)*

It is not immediately obvious that the '6 main components of the integrated health care framework' relate to the full diagram of the framework on the cover and final page of the document. For better clarity, we recommend inserting the full diagram of the framework at this point.

The College notes that 'patient centred integrated care' is the goal – rather than a component of – the Framework and thus should not be included in the list of components. Differentiating 'person-centred integrated care' from the other components also makes more sense when looking at the full, circular diagram.

Pharmacist-doctor collaboration (page 9)

The College notes that the results from its 2015 Workforce Survey may be of use in this section. In this survey, the College asked about the frequency and types of interactions that GPs had with other health professionals. A summary of these results and an accompanying explanation can be made available on request.

With respect to Table 2 (page 10), we note that 'sustainability requirements' are included as a component of collaboration and that it mentions programmes designed for community pharmacy. On this point, the college acknowledges the important role of community pharmacies in rural and regional areas where there is commonly reduced access to healthcare.

However, the College asserts that a community pharmacist cannot safely be considered a replacement for a diagnostician and there is some concern about the implementation of programmes like brief interventions and treatment of minor ailments in these settings. While it is tempting to say that simple diagnosis and treatment of UTIs or other common conditions might be done in a community pharmacy, the reality is that it takes considerable knowledge and skill to know when it is a simple, uncomplicated diagnosis and not an indicator of something more serious. Patient privacy and the conflicts of interest that arise when a diagnostician is also a seller of the treatments also remain serious concerns.

Practice innovation / service / model of care (page 11)

Patient preferences for where care should be delivered is undoubtedly important, but should be tempered with ethical and safety measures. For example, the retail environment of some community pharmacies poses serious ethical concerns for ensuring the most appropriate treatments (or absence of treatment) is offered. Conversely, the College is supportive of onsite pharmacists and understands that co-location of services is already occurring. One member commented that a major barrier to this kind of integrated care can be the cost of building or reserving a consultation room in a practice for this purpose.

Influences: The factors influencing an integrated person-centred care, innovation or service (page 12)

An additional aspect that the College recommends including as part of the evaluation of influences, is the sharing of evaluation reports. That is, there are frequently pilots of innovative models of care and services that are evaluated, but not well publicised or shared among the health sector. Sharing findings on what does and does not work well is crucial to making progress and avoiding future unnecessary costs or poor outcomes. The College is interested in promoting well-evidenced innovative new models that improve access to quality, patent-centred care.

3. Implementation

Integrated health care framework template (page 15)

As noted earlier, the template cleverly pulls together the many aspects of the Framework and asks the right questions. However, it is unclear who would be using the Framework and Template (e.g. practice manager, clinicians, a PHO planner/funder etc). Clear identification of who the template is aimed at would be helpful.

Examples (pares 19 – 30)

While the College supports the use of General Practice Pharmacists as an example, it is does not consider the reclassification of medicines (such as Trimethoprim) to be an appropriate use of this framework.

One key comment that members made was that low-risk patients, regular check-ups, and simple interventions like immunisations or UTI management are actually important and useful visits for GPs to receive. While it does not require the physician to work at the 'top of scope', it is helpful to see patients when they are relatively well as it provides a benchmark for that patient when they are not well. Additionally, there are benefits in the comprehensive and continuous care that an identified single general practitioner responsible for the oversight and management of a patient's health care experience brings.[1-5]

Seeing 'simple' cases is also important to reducing burnout: A full day of complex or difficult patients can be psychologically and physically hard on the doctor.

An illustration of medicines management in a collaborative integrated care environment – A patient journey (page 31)

One member noted that in this example, there are at least 10 interactions between the patient, GP, and two different pharmacists including the multidisciplinary team meeting. The Practice Nurse who would usually be involved with such a patient is only mentioned once as part of the multidisciplinary meeting. Each GP or practice has numerous patients like Mrs Smith and that the high frequency (and funding requirements) of interactions is unlikely to be practicable – particularly as the population ages.

The College looks forward to receiving the final version of this framework, and contributing to the PSNZ and NZMA's goal of better enabling integration between pharmacists and GP to provide equitable, patient-centred care.

We hope you find our submission helpful. Should you require any further information or clarification please contact the College's policy team at policy@rnzcgp.org.nz.

Yours sincerely,

Michael Thorn
Manager – Strategic Policy

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