Inquiry into Community Pharmacy

To: Secretary
Legal and Social Issues Legislation Committee
Inquiry into Community Pharmacy
Parliament House
East Melbourne VIC 3002

Submitted by: Eastern Melbourne Medicare Local
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Approved by: Chief Executive Officer

Eastern Melbourne Medicare Local (EMML) is delighted to provide this submission to the Victorian Inquiry into Community Pharmacy. Pharmacists are currently a grossly underutilised resource within the health care system in Australia, necessitating the expansion of their roles outside of the walls of a pharmacy and into other community settings, especially aged care and post-acute health care settings. Placing pharmacists into these settings would enable significant health benefits for the community as well as decreased health care costs to government through reduced unplanned hospital admissions and increased efficiency and effectiveness of the healthcare system. This submission provides a brief overview of current thinking in practice in relation to the role of pharmacists in these settings, drawing on relevant national and international literature.

The difference between a Pharmacy and a Pharmacist

It’s important to differentiate between a pharmacy and pharmacists. A pharmacy is a premises where medicines and services are provided. A pharmacy is either a hospital pharmacy (on a hospital premises) or a community pharmacy (a “chemist” shop such as that at your local shopping centre). A pharmacy always has a pharmacist on duty.

A Pharmacist is a university qualified health care professional who is the most highly trained health care professional in relation to medicines. The expertise and scope of practice of a pharmacist goes beyond the supply of medicines and/or the provision of medicines-related information, to also include the identification and prevention of problems with medicines such as drug interactions, dosage related problems and selecting the most appropriate medicine for the patient. Whilst most pharmacists work in a pharmacy, their skills and knowledge make them ideally placed to make contributions to patient care well beyond the role of medicines supply. Pharmacists are often incorrectly viewed as little more than “box labellers” who work only in a pharmacy, but their in-depth and extensive medicines knowledge makes them a valuable member of any health care team.
The difference between a Pharmacist and a General Practitioner (GP)

It is also important to recognise that whilst there is some overlap in the roles and knowledge of medical practitioners and pharmacists, the two professions have differing strengths and focus of expertise. Recently published research exploring GPs views of pharmacist conducted medication reviews demonstrated that GPs felt that pharmacists’ greater knowledge of pharmacology, dosage forms, adverse drug effects and drug interactions would be an asset in helping to improve patient safety (1). Pharmacists are not a lesser version of GPs, but rather a specialist in their field. GPs often refer to a medical specialist when more specialised knowledge is required and this same principle should be applied to pharmacists and medicines. In other words, as the complexity of a person’s medicines regimen increases, a referral should be made to a medicines specialist - the pharmacist.

Collaborative prescribing decision making

An example of how a pharmacist can improve medicines management outside the walls of a pharmacy is the Home Medicines Review (HMR) and Residential Medication Management Review (RMMR) programs. The HMR program involves an accredited pharmacist (pharmacists who have undergone additional and ongoing training and assessment to undertake HMR/RMMRs) undertaking a comprehensive medication review in the patients home. The RMMR program is a similar service but is conducted in residential aged care facilities. Both services require GP referral. Whilst accredited pharmacists have optimised the medicines regimen and decreased the risk of harm to thousands of patients via these programs, HMR/RMMR is a reactive service delivered to patients who have potentially been on suboptimal medicines regimens for quite some time (a patient is generally only eligible for one of these services every 2 years). A more efficient and most likely cost effective approach to improving patient safety would be to have the pharmacist involved in the prescribing decision making process from the start - at the time of medical practitioner decision making.

One USA study showed that having a pharmacist side by side with the prescriber at the point of patient evaluation reduced adverse drug events by 78% (2). Given that around 1 in 3 unplanned hospital admissions involving older Australians are due to problems with medicines and that half of these medicine problems could be prevented (3), it would seem to make sense to have pharmacists working collaboratively with prescribers at the point of decision making, by the bedside-especially when prescribing for the elderly on multiple medicines. Given that the annual cost of medication-related admissions is estimated to be $1.2 billion, it would seem to make good economic sense also (4).

Improving safety in the aged care setting by having an RACF onsite pharmacist

While pharmacies and pharmacists currently already partner with Residential Aged Care Facilities (RACFs) in the supply of medicines and quality use of medicines (QUM) activities (such as a medication advisory role, staff education and continuous improvement activities) the supplying pharmacist has limited (if any) information about patients medical conditions, symptoms of concern or pathology results. So, while supplying pharmacists are currently

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Inquiry into Community Pharmacy

able to assess issues such as drug interactions and medicines duplication, they are generally unable to provide their expertise on the following issues due to the lack of access to patient information:

- ensuring the dosage is appropriate relative to renal function (a study of 1000 elderly Australians undertaken by Roughead et al found that 45% of doses prescribed for patients with renal impairment were inappropriately high)(5)
- ensuring appropriate monitoring is being undertaken (Roughead et al found that 1 in 3 were not receiving adequate medicines related monitoring )(5)
- identifying medicines that may be causing signs/symptoms the patient is experiencing
- ensuring the most appropriate medicine is selected (studies show between 40-50% of residents in aged care are prescribed potentially inappropriate medicines)(4 p14)
- omission of therapy (Roughead found 1 in 4 patients needed additional medication than had been prescribed by their medical practitioner)(5)

An RACF onsite pharmacist would be able to provide this additional level of clinical expertise to optimise patient safety. Another very important task that an onsite RACF pharmacist could provide is medication reconciliation at the point of entry to RACF and on hospital to RACF transfer. It is well recognised that transfer of care is a high risk time for the development of medicines related problems.

Given that up to 96% of residents in aged care facilities have been found to have at least one medication-related problem(6), it is reasonable to assume that the expansion of the roles for pharmacists to aged care settings could have a range of benefits in terms of improved patient outcomes and reduced costs to the health care system.

Developing strategies to reduce the inappropriate use of anti-psychotics in people with dementia is currently a national priority, with the Senate releasing a report outlining recommendations aimed at decreasing the inappropriate use of anti-psychotics in people with dementia, amongst other issues. Pharmacists located in RACFs would be ideally placed to not only ensure the safe and judicious use of anti-psychotics in facilities but also to review patient’s current medicines and to identify those medicines which may be contributing to causing the behaviour of concern which led to anti-psychotic prescribing in the first place. Pharmacists are expertly placed to review medicines that may be contributing to the behavioural and psychological symptoms of dementia as well as other medicines causing common geriatric presentations eg falls, incontinence, bleeding, confusion (a DVA database study showed 61% of those admitted to hospital for acute confusion were dispensed multiple psychotropic medicines in the 3 months prior to admission)(4).

Home visiting pharmacists

Whilst accredited pharmacists currently visit people in their homes via the HMR program, there are various barriers which have plagued the successful and widespread uptake of this program such as the requirement for a GP referral. Other settings where pharmacists could make valuable contributions to health care teams caring for the elderly would be in teams of
Inquiry into Community Pharmacy

home visiting nurses (half of RDNS visits relate to medicines support).
Incomplete/ inaccurate medicines lists are a common challenge faced by RDNS (7).
Pharmacists are ideally placed to reconcile medicines lists and ensure the patient’s medicines are safe and appropriate. Other potential models for optimising the medicines regimen of the elderly who live at home would be to have a home visiting pharmacist service where the service is triggered by those patients at high risk of a medicines related problem, especially those recently discharged from hospital. Liaison between the GP, hospital and community pharmacy to conduct medication reconciliation services would have potential to decrease the risk of unplanned hospital readmission.

Pharmacists in General Practice

Another collaborative team model which warrants serious consideration is the co-location of pharmacists into general practice. GPs recognise their limitations in relation to medicines review as being time limitations, heavy workloads and limited knowledge of pharmacology and drug interactions (1). Given the tendency for the elderly to be on complex medicines regimens which would benefit from medicines review and collaborative prescribing decision making, there is a clear role for pharmacists in GP settings. Having the pharmacist onsite in the practice would allow them greater access to more patient information (such as disease states and pathology results) than they would normally have access to. This would allow for collaborative decision making processes, checking for drug-drug and drug-disease state interactions, ensuring appropriate monitoring is being conducted, rationalising complex regimens and the provision of in-depth medicines information to the patient to improve patient adherence etc. Having case conference item numbers for pharmacists on the MBS would be one way of funding such a model of care. As would allocating pharmacists a claimable MBS item number for involvement in GP management plans and team care arrangements. Tan et al found that 79% of patients attending general practice had at least 1 medicines related problem and that this could be decreased to 45% by the intervention of a co-located pharmacist (8). Studies that have integrated pharmacists into primary care practices have shown improved patient outcomes (9). A co-located pharmacist could also deal with the complex and time consuming task of reconciling medicines lists - particularly of hospital discharge patients. As pointed out by the Society of Hospital Pharmacists of Australia (SHPA), medication review and reconciliation should be undertaken whenever the patient is transferred from one setting to another and that pharmacists obtain more accurate medication histories than do other health professionals (10).

Preventing medicines related problems by working collaboratively with other health care teams

Patients and health care professionals are often unaware that a problem exists with a medicines regimen or the way the medicines are taken until an adverse outcome has occurred. Pharmacists are the best placed health care professionals to identify these problems before they occur and to make suggestions which maximise the safety and efficacy of medicines. Pharmacists are likely to improve health outcomes and reduce pressure on other services if located in settings such as:
Inquiry into Community Pharmacy

- Community health centres (who have frequent contact with high risk groups such as the elderly and people with diabetes)

- Falls prevention teams (falls and postural hypotension account for around one quarter of medicines related presentations to hospital amongst the elderly)(11)

- Cardiac and Pulmonary rehabilitation teams

- Mental health teams (the positive impact of having pharmacists as part of mental health teams has been explored by researchers such as Bell et al)(12)

- Palliative care services

- Aboriginal health services

- Aged Care Assessment Teams (ACAT) teams and other home visiting teams for the elderly (evidence from a randomised controlled trial strongly supports the role for a clinical pharmacist within an ACAT team setting)(13)

- Case management teams

Pharmacists are also of great value in health care settings in non-clinical roles by educating and connecting health care teams to clinical pharmacy services. For example, the following programs in Eastern Melbourne Medicare Local have benefited from education and connection from a Pharmacist:

- Partners in Recovery

- Mental health nurse teams

- Headspace

- Closing the Gap

- Care coordination and supplementary services program

- Health care professional events planning

- Australian Primary Care Collaboratives Program

- Health Pathways

- E-health

- Aged Care programs

- Population Health teams

- After Hours
In conclusion, this submission demonstrates evidence for a range of key benefits and potential health and cost effectiveness outcomes associated with the expansion of the role of pharmacists into community and aged care settings.

References


(8) Tan et al. (2012). An exploration of the role of pharmacists within general practice clinics: the protocol for the pharmacists in practice study (PIPS). BMC Health Services Research, 12:246


Inquiry into Community Pharmacy