Integrating pharmacists into primary care teams

Better health outcomes through cost-effective models of care
Pharmacists are highly trained, have deep expertise in medicines, and are located in communities throughout Australia. But their role is far more limited in Australia than in many other countries.¹
Summary

Team-based models of primary care have emerged in response to growing health system demands created by increasingly complex patients.

Such models are correlated with improvements in equity, access and lower costs, as well as improvements in population health.²

Furthermore, as Pharmaceutical Benefits Scheme (PBS) spending per person is projected to increase by 22% by 2020³, having a pharmacist contribute to more cost-effective prescribing provides a mechanism for ensuring the future sustainability of the PBS for all Australians.

This submission aligns with the key elements of Australia’s policy on Quality use of medicines and in particular focuses on the safe and effective use of medicines to achieve the best possible results⁴ by: monitoring outcomes; minimising misuse, over-use and under-use; and improving people’s ability to solve problems related to medication, such as adverse effects or managing multiple medicines.

Pharmacists are highly qualified health professionals yet their skills, knowledge and expertise are often under-recognised and under-utilised. Australia now has a large and growing pharmacist workforce that is highly trained and with a much younger age-profile than most other health professions.

Pharmacist-delivered medication management and education services are the missing link in most general practices and Aboriginal Health Services. There are opportunities in these settings for a non-dispensing pharmacist to work with other members of the health care team to improve medication use and reduce errors for consumers with chronic disease.

This submission highlights two key areas in which existing health resources can be better coordinated and targeted within a collaborative primary health care model to improve health outcomes for Australians. Specifically, it identifies opportunities to better utilise the skills and expertise of pharmacists to address the Government’s policy objectives in the following areas:

1. Improving health outcomes and cost-effectiveness of primary care
   PSA recommends that Government introduces a Pharmacist Incentive Payment (PhIP) to integrate pharmacists within general practices to deliver medication management services within a collaborative framework.

2. Improving health outcomes for Indigenous Australians
   PSA recommends that Government supports Aboriginal Health Services to integrate pharmacists within their teams to deliver essential medication adherence and education services in a culturally appropriate environment.
Background

“Improved primary health care is fundamental to achieving better health outcomes”

As part of its commitment to a sustainable health system, the Government has acknowledged that primary health care is best positioned to manage chronic disease and support preventive health, easing pressure on the hospital system. The former Health Minister expressed a desire to find solutions now for a sustainable health system into the future, and foreshadowing the difficulty in finding money to pay for the services demanded by the increased burden of long-term health conditions.

Medicines use is increasing

The growing burden of chronic disease is seeing a commensurate increase in medicines use. Over 80% of Australians aged 65 years and over, and about 70% of Australians aged 45-64 regularly use pharmaceuticals, with these proportions expected to further increase.

Medicines are the most common treatment used in health care and contribute to significant improvements in health when used appropriately. Australia spends over $16 billion each year on medicines or around $700 for every man, woman and child in Australia – every year. By comparison, we don’t spend very much on medication safety and we don’t pay anywhere near enough attention to reducing the occurrence and severity of medication errors.

All medicines have the potential for side effects and can interact with other medicines. Each year 230,000 people are admitted to hospital, and many more people experience reduced quality of life, as a result of side effects of their medicines. This comes at a cost to the system of more than $1.2 billion. The COAG Reform Council’s recent report documented increases in potentially preventable hospital admissions.

Much of this personal and financial burden is preventable, with increasing evidence of the impact that pharmacists can have on medication safety and adherence, and the resulting savings to the health system.

Aboriginal and Torres Strait Islanders continue to experience worse health

It is not only ageing Australians with increasing co-morbidities who will continue to be exposed to the risk of medication misadventure unless improved multi-disciplinary systems and process are developed, evaluated, implemented and...
integrated across health care settings. Aboriginal and Torres Strait Islander people have two-to-three times higher levels of illness than non-Indigenous Australians.

This is a key area of policy focus for the Government, who have indicated their commitment to achieving health equality between Indigenous and non-Indigenous Australians within a generation.

Together with changes to lifestyle factors, long term medicine treatment is usually needed to prevent or reduce disease progression and thereby minimise or delay negative outcomes of ill health. Despite the high burden of chronic disease, under-use of medicines amongst Aboriginal and Torres Strait Islander people persists, due to a range of factors.

Without improved medicine information and increased medicine adherence, it is likely that chronic disease for Aboriginal and Torres Strait Islander people will remain poorly controlled and morbidity and mortality rates will remain high.

Importance of medication adherence

Adherence to a medication regimen is central to good health outcomes. However, evidence is emerging that there is an increase in patients failing to collect their prescriptions. Medication adherence for many patients with chronic disease is extremely poor, resulting in disease-related complications, higher levels of hospitalisation, and increased morbidity and mortality.

The economic costs of non-adherence are high. Central to good adherence is the quality of the health professional/patient relationship and effective health communication. The Compliance to Medicines Working Group Report to the Pharmaceutical Benefits Advisory Committee highlighted the importance of the patient/clinician relationship and also identified that “consumers value advice from a variety of health professionals about their medicines.”

Optimising the management of long-term conditions

Chronic diseases, or long-term conditions, place significant demands on the health care system and incur significant health care costs associated with medicines, diagnostic services, aged care, medical services and in particular, hospital expenses. In 2011 around 240 million prescriptions were dispensed through the PBS at a cost of $8.3 billion to the Australian Government and a further $2 billion in patient co-payments to pharmacies. For the PBS in particular, spending per person is projected to increase by 22% over the period to 2020.

Optimising the management of long-term conditions through quality use of medicines (QUM) has been shown to reduce or delay the incidence of hospitalisation in patients with chronic diseases and to reduce the need for, and spending on, expensive hospital admissions and medical services.

The Government, through its policy Healthy Life, Better Ageing seeks to address these rising costs and improve quality of lives. For most people the use of medicines is just one element of contribution to good or better health. This submission recognises the importance of a coordinated, team care approach where health professionals with different skills and expertise work in partnership to deliver care in a synergistic, cohesive and holistic manner. Such an approach was recommended by the National Health and Hospitals Reform Commission in its final report:

“We recommend improving the way in which general practitioners, primary health care professionals and medical and other specialists manage the care of people with chronic and complex conditions through shared care arrangements in a community setting.”

About PSA

The Pharmaceutical Society of Australia (PSA) is the peak national professional pharmacy organisation representing Australia’s pharmacists working in all sectors and locations.

PSA’s core functions include:

• providing high quality continuing professional development, education and practice support to pharmacists;
• developing and advocating standards and guidelines to inform and enhance pharmacists’ practice; and
• representing pharmacists’ role as frontline health professionals.

PSA is also a registered training organisation and offers qualifications including certificate and diploma-level courses tailored for pharmacists, pharmacy assistants and interns.

80% of the life-expectancy gap between Indigenous and non-Indigenous Australians can be attributed to chronic diseases such as heart disease, diabetes and liver disease.
This unfortunately leaves Australia lagging behind in terms of applying the evidence; the models in which significant benefits have been demonstrated internationally are GP-led, but use an expanded staffing model in which nurses, pharmacists and others assume greater care management roles.46

Pharmacists are accessible health practitioners who, by working within a collaborative framework, can assist Government to achieve fiscally sustainable, efficient and quality healthcare.

This submission highlights two key areas in which existing health resources can be better coordinated and targeted within a collaborative primary health care model to improve health outcomes for Australians. In particular, it focuses on the safe and effective use of medicines to achieve the best possible results by: monitoring outcomes; minimising misuse, over-use and under-use; and improving people’s ability to solve problems related to medication, such as adverse effects or managing multiple medicines.

Pharmacist-delivered medication management and education services are the missing link in most general practices and Aboriginal Health Services (AHSs). There are opportunities in these settings for a non-dispensing pharmacist to work with other members of the health care team to improve medication use and reduce errors for consumers with chronic disease.

This submission acknowledges the important role and significant impact that pharmacists can have on issues relating to health literacy and medication adherence and identifies opportunities to better utilise the skills and expertise of pharmacists to address the Government’s QUM policy objectives.47

PSA recommends through the following proposals, that the Federal Government, in its 2015-16 Budget, allocates funding for practice pharmacists to work in general practices and Aboriginal Health Services to improve the quality use of medicines through a coordinated, collaborative and integrated approach to care.

Pharmacists are an integral part of the primary care team

Pharmacists are highly qualified health professionals yet their skills, knowledge and expertise are often under-recognised and under-utilised. Australia now has a large and growing pharmacist workforce that is highly trained and with a much younger age-profile than most other health professions. After doctors and nurses, pharmacists are the largest health workforce.35 Moreover, the workforce size is keeping pace with demand as compared with other health professions that are experiencing contractions in their workforces.35,36

Contemporary pharmacist training, often involving multidisciplinary teamwork, makes them ideally placed to take on collaborative roles.

During the recent debate that followed the proposal to introduce a co-payment for general practitioner (GP) services37, some health policy experts suggested that the Government look instead to the existing health workforce.38

The Grattan Institute report on solutions for GP shortages in rural Australia underscored the need for GPs to be better supported by pharmacists and other health professionals.39

The breadth of locations in which pharmacists work, and their important contribution in each of these settings (see Box 1), is well aligned with the shift towards more collaborative and patient-centred models of health care designed to improve the efficiency and effectiveness of the health system, particularly for consumers with chronic disease.42,43

The role for Australian pharmacists in collaborative, consumer-centred models has thus far been described in very limited and peripheral terms,44 in contrast to international models.45

Box 1. Pharmacists can contribute to better medication management by (non-exhaustive)41:

- Identifying, resolving, preventing, and monitoring medication use and safety problems
- Reducing poly-pharmacy and optimising medication regimens on the basis of evidence-based guidelines
- Recommending cost-effective therapies
- Designing tailored adherence and health literacy programs
- Developing consumer medication action plans with self-management goals
- Communicating medication care plans to consumers, carers and other health care professionals in the team.
Integrating pharmacists into General Practice

‘Pharmacists co-located in general practice clinics can deliver a range of interventions, with favourable results in chronic disease management and quality use of medicines.’\textsuperscript{48}

The integration of pharmacists within the general practice setting has been adopted by the NHS alliance in the UK.\textsuperscript{49}

Many other countries, including New Zealand, Canada and USA, have pharmacists providing clinical services in general practice settings.\textsuperscript{50}

In Australia, the concept has received endorsement from leading medical organisations, acknowledging the value pharmacists add to the primary healthcare team.\textsuperscript{51,52}

**Role**

A practice pharmacist is best defined as one who delivers clinical pharmacy and education services from or within a general practice medical centre or other primary care practice (multidisciplinary clinic, Aboriginal Health Service) through a coordinated, collaborative and integrated approach with an overall goal to improve patient outcomes through QUM.\textsuperscript{53}

The practice pharmacist role is diverse and should be adapted to the needs of the practice setting and their patients.\textsuperscript{54} The core roles include patient consultations, medication information and education, and drug use evaluation (see Box 2).

Practice pharmacists assist with medication enquiries from patients and health professionals, conduct staff education, contribute to optimal prescribing, mentor new prescribers, participate in case conferences, liaise across health sectors, undertake medication management reviews, and evaluate drug utilisation to ensure optimal therapy.\textsuperscript{55} Other roles pharmacists could undertake included point-of-care testing (e.g. blood pressure, blood glucose, International Normalised Ratio [INR]) and monitoring, clinical audits, health assessments, immunisation, transitional care and facilitation of shared medical appointments.\textsuperscript{56,59}

As part of their collaborative work, an important element of the practice pharmacist’s role is liaison with local community pharmacists, to ensure continuity of care.

‘THE SKILLS OF HEALTH PROFESSIONALS ARE NOT BEING USED PROPERLY. USE OF ALL THE SKILLS OF OTHER PROFESSIONALS, SUCH AS NURSES AND PHARMACISTS, NEEDS TO BE ENCOURAGED.’\textsuperscript{40}
Practice pharmacists have noted that being able to access the patient’s medical file for a complete patient history enables meaningful, informed clinical interventions and enhances pharmacist–GP communication and collaboration.60,61 Full access by the pharmacist to the patient’s medical records is a necessity in order to provide optimal patient care.52

Current challenges
The major documented obstacles to effective GP-pharmacist collaboration in Australia include geographical isolation, poor communication, lack of time and lack of remuneration.63,64

PSA is aware that there are currently approximately 26 pharmacists working on average 18 hours per week within GP practices in Australia. The majority of these rely on remuneration from conducting Home Medicines Reviews (HMRs) to compensate for providing other unpaid services.65

However, restrictive criteria of the HMR and Residential Medication Management Review (RMMR) programs create limited scope of services. The absence of remuneration for practice pharmacist-delivered services has been identified as the biggest hindrance to the advancement to this area of practice in Australia.66,67

As outlined above, there are opportunities in general practice for a non-dispensing pharmacist to work with other members of the health care team to improve medication use and reduce error for consumers with chronic disease. However, this is only possible in very limited circumstances due to existing arrangements and funding restrictions. Currently a GP can call on the specialist skills of, for example, a nurse, physiotherapist or psychologist to help them meet the needs of consumers with chronic disease under programs nationally funded through the Medicare Benefits Schedule (MBS),68,69 yet a pharmacist can’t easily be included in the practice team to review and advise on the consumer’s medicines regimen.

Given the central role of medicines in the care and treatment of consumers with chronic disease, this doesn’t make sense. Many consumers with chronic diseases are missing out, and an opportunity to improve their health is being lost.

Proposed solution
PSA and the Australian Medical Association (AMA) have developed a possible model which is outlined below. The model is based on the Practice Nurse Incentive Program (PNIP) which provides payments to general practices to support an expanded and enhanced role for nurses working in general practice.70 It is suggested that the Australian Government funds a similar program for pharmacists. A Pharmacist Incentive Payment (PhIP) would support the cost of employing a pharmacist for the majority of general practices.

The PhIP would pay $25,000 per year per SWPE* with a pharmacist working a minimum of 12 hours 40 minutes per week. Incentives would be capped at five per practice meaning that practices would be eligible to receive up to $125,000 per year to support their pharmacist workforce. A loading of up to 50% should apply for rural practices.

In line with the requirements for the PNIP, a practice must meet certain requirements to be eligible to receive the PhIP (see Box 3).

* The Standardised Whole Patient Equivalent (SWPE) value of a practice is the sum of the fractions of care provided to practice patients, weighted for the age and gender of each patient. The average full-time GP has a SWPE value of around 1000 SWPEs annually. http://www.medicareaustralia.gov.au/provider/incentives/pip/payment-formula/#N101B6

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**Box 2. Examples of ways in which pharmacists can assist within a general practice (non-exhaustive)** 55,56:

**Staff-directed services**
- Sharing current drug information with doctors and practice staff
  - Education sessions
  - New evidence & therapeutic uses
  - New guidelines (summarized)
  - Teaching students & registrars
  - Patient education seminars
- Responding to medicine queries
  - PBS queries
  - Sourcing medications
  - Specific medication concerns from GPs e.g. switching anticoagulants, antidepressants, opioid equivalence
  - Questions about medication formulations
- Increasing practice efficiency and freeing up GP time
  - Providing seamless care with community pharmacists
  - Prompt medication reviews and advice

**Patient-directed services**
- Providing in-practice referral based medicine reviews
- Private consultations for medication-based concerns for patients
- Documentation and patient follow up on adverse drug events
- Counselling on smoking cessation, lifestyle issues and medicine-based activities
- Assisting patients navigate the health system and medication changes between health settings

**Practice based quality assurance activities**
- Documenting and follow up adverse drug events
- Optimising medication regimens
- Drug utilisation reviews (DURs)/Drug use evaluations (DUEs)
- Monitoring and advising on prescribing practices
Demonstrated benefits

A recent systematic review indicated co-location of pharmacists in general practice clinics resulted in interventions which significantly improved blood pressure, glycosylated haemoglobin (diabetes), cholesterol, osteoporosis management and cardiovascular risk. Patient consultations resulted in significant reductions in medication-related problems and improvements in medication adherence.

Co-location also enabled greater communication, collaboration and relationship building among the health professionals. Unsurprisingly, there was a significantly higher rate of uptake of a practice pharmacist medication review recommendations by the GP.

GP-based practice pharmacists in the UK have been said to "contribute hugely to patient care and support the medicines optimisation agenda. Patient empowerment is enabled and patients have a forum whereby complex medicines-related queries can be answered, thus supporting adherence and improvement in health outcomes."

Moreover, the 2010 UK PINCER and PRACTICE studies found that pharmacists play a critical role in reducing medicine errors in general practice.

Integrating pharmacists in general practice not only helps to ensure the best outcome in terms of minimising potential adverse effects, but also achieves more cost-effective prescribing, with cost savings shown from $44-$101/patient.

Therefore in addition to positively contributing to the Government’s QUM objectives, this initiative will contribute to a more sustainable PBS. Furthermore, it will minimise upward pressure on the PBS patient co-payment, improving the future access and affordability for Australians.

The integration of pharmacists in GP practices needs to be afforded a priority by the Australian Government in its attempts to build a more effective primary care system.

Box 3. To be eligible for the proposed PhIP, a practice must:
- be accredited or registered against the RACGP Standards for general practice
- maintain practice accreditation
- have public liability insurance and GPs must have professional indemnity cover
- employ or retain services of a GP
- employ or retain services of a registered pharmacist/s
Integrating pharmacists into Aboriginal Health Services

Appropriate, effective interactions of Aboriginal and Torres Strait Islander people with culturally responsive clinical pharmacists could improve medication adherence and reduce the progression of chronic disease.81

Poor adherence to prescribed medicines is well documented and associated with adverse health outcomes in all population groups.82 Social circumstances, deficiencies in health services and systems mean Aboriginal people often suffer even greater challenges in medicine management than non-Indigenous Australians. Social and emotional wellbeing issues may deeply pervade the lives of many Aboriginal people and may diminish the value that individuals place upon medicines and the potential of these medicines to improve their quality of life.83

Aboriginal Health Services (AHSs) play an important role in the primary health care of Aboriginal and Torres Strait Islander people.84 AHSs are comfortable, safe environments that understand and address Aboriginal patients’ needs. AHSs are multidisciplinary services which address the need for more holistic, accessible primary healthcare services for Aboriginal and Torres Strait Islander people.

Having pharmacists embedded within AHSs would facilitate the training of culturally responsive pharmacists and the building of relationship and trust between pharmacists and AHS Aboriginal patients and staff. Such relationships with patients together with closer collaboration with AHS GPs and other health professionals could assist continuity of care and empower Aboriginal and Torres Strait Islander people in their medication choices and management.

Role

A clinical pharmacist employed within an AHS would deliver medication advice and education to consumers and staff, and work with both consumers and other health professionals to improve medication adherence and reduce medication misadventure through tailoring medication regimens and overseeing medication management processes.

Other activities that pharmacists are well-equipped to deliver within an AHS include health promotion, disease prevention initiatives, and assistance with...
consumer self-management and judicious use of medicines (see Appendix 2). A pharmacist in an AHS could deliver the same services as outlined in the General Practice proposal above.

Improving medication adherence is often complex and multi-factorial and requires interventions at the system, provider and consumer level. Pharmacists can make a significant contribution at each of these levels. They can empower individuals, assess consumer needs and tailor solutions, and maximise the benefits arising from the health system by promoting timely and equitable access to medicines. Pharmacists can provide QUM education for Aboriginal and Torres Strait Islander people and health professionals. Those pharmacists already working with Indigenous Australians assist with medication adherence through simplification of medication regimens, education for self-management and ongoing support and monitoring.

Without improved medicine information and increased medicine adherence, it is likely that chronic disease for Aboriginal and Torres Strait Islander people will remain poorly controlled and morbidity and mortality rates will remain high.

Pharmacists, who can ensure safe and effective medicine use, increase patient medication knowledge and provide education to health service staff, are particularly needed in remote areas, where there is often a scarcity of medical practitioners and lack of continuity of health professional staff.

Current challenges

Despite the high burden of chronic disease, there has been longstanding under-use of medicines amongst Aboriginal and Torres Strait Islander people, especially in remote areas. Barriers to accessing medicines for remote Aboriginal and Torres Strait Islander people include financial and geographic constraints, failed patient-clinician interactions, poor healthcare delivery systems and complex therapeutic medication regimens. Other barriers include poverty, racism, dispossession, lack of control, the stigma associated with a diagnosis of chronic disease, educational disadvantage, shared crowded households, increased patient mobility, and inadequate health professional support.

The number of GP services per person in the lowest access rural areas is less than half that of the major cities. Similarly 76% of pharmacists work in urban areas. There are many rural areas with little or no pharmacy services and many of Australia’s rural hospitals operate without an onsite pharmacist due to lack of funded pharmacist positions.

There is often much confusion around medicines and many Aboriginal and Torres Strait Islander patients in all locations still have low levels of medicine adherence relating to lack of appropriate or tailored

- More than 80 per cent of people over 65 have 3 or more long-term health conditions.
- Two-thirds of Australians over 75 are on 5 or more medicines.
- Medication-related admissions account for 20-30% of all hospital admissions for people over 65.
information, and lack of health professional engagement and patient support.\textsuperscript{91, 92}

Initiatives already in place such as the Aboriginal Health Service Remote Access (AHSRA or Section 100) Scheme, the Quality Use of Medicine Maximised for Aboriginal and Torres Strait Islander peoples (QUMAX) program and the Closing the Gap PBS Co-payment measure (CTG) have removed some of the financial barriers to accessing medicines, and have resulted in some increases in medicine utilisation by Aboriginal and Torres Strait Islander people. However, complex medicine regimens result in some Aboriginal and Torres Strait Islander people finding medicines confusing and difficult to manage. Currently, communication from the doctor and/or pharmacist about medicines is often incomplete or ineffective. Dispensing protocols, the lack of pharmacist interaction and cultural training, and the physical settings of community pharmacies have made it difficult for some Aboriginal and Torres Strait Islander people to have productive relationships with their community pharmacists.\textsuperscript{93}

HMR accredited pharmacists are currently providing very limited clinical pharmacy services to Aboriginal Australians. Although pharmacists would like to provide more HMRs to Aboriginal people the absence of pharmacist-AHS relationships are barriers to providing this service.\textsuperscript{24}

Proposed solution

PSA recommends that the Federal Government consider an an adaptation of the PhIP to allow Aboriginal Health Services (AHS) across Australia to improve medication adherence and reduce the progression of chronic disease, by integrating clinical pharmacists in the AHS team. This would allow Australia’s 200 AHSs to access up to $125,000 per year to employ a pharmacist, in keeping with the general practice proposal. This initiative would give AHSs around Australia much greater access to the expertise of a pharmacist and where required, to deliver essential medication adherence and medication education services in a culturally appropriate environment.

**Demonstrated benefits**

Appropriate, effective interactions of Aboriginal and Torres Strait Islander people with culturally responsive clinical pharmacists could improve medication adherence and reduce the progression of chronic disease.\textsuperscript{95}

Greater understanding and empowerment about medicine choices are likely to improve medicine adherence. In some cases, limited pharmacist interaction, and the physical settings of community pharmacies have made it difficult for Aboriginal and Torres Strait Islander patients to have productive relationships with pharmacists.\textsuperscript{96}

Investment by the Government in such initiatives would be offset by reductions in chronic disease expenditure and reduced hospitalisations for the population of Australians beset by the poorest health outcomes. Making better use of pharmacists to improve the QUM by Indigenous Australians must be an integral element in the Government’s efforts to achieve health equality between Indigenous and non-Indigenous Australians.
Solutions for a stronger, more sustainable primary care system

“Structural changes [are required] to improve seamlessness of care to ensure that a person with chronic illnesses has access to all the professional skills needed.” 97

Together with a focus on healthy ageing, the Government identified a focus on early intervention in primary care as one of its key policy objectives,96 with a commitment made to: “Strongly support improved coordination of care between doctors, practice nurses and allied health professionals.”97

The Government has much to gain from investing in initiatives that improve coordination and management of chronic conditions. There is growing evidence that this results in improved utilisation of resources, including medicines and ancillary health services, leading to improved health outcomes.100

Pharmacists are ideally placed to support their fellow health professionals and improve the quality of care for patients (see Box 4).

Yet structurally, the health system is effectively working against these goals. Currently almost all funding for pharmacist-delivered services comes not from within the MBS where the other programs sit, but from the PBS as part of the Community Pharmacy Agreements. This leaves the pharmacy programs largely isolated from other programs administered by different sections within the Department of Health.

Without collaborative and integrated arrangements, a large number of Australians with chronic diseases are missing out, and an opportunity to improve their health is being lost.

Emerging evidence suggests that ensuring the sustainability of the health system will be more about reducing wasteful spending than imposing cuts on critical elements of primary care – including pharmacists.101 There is room in the system to make these smarter investments if the right structural changes are made.102

There is great potential to positively impact the health outcomes and quality of lives of all Australians, while reducing costs. Pharmacists are critical to the Government’s efforts to achieve sustainable, efficient and quality healthcare.
# Appendix 1

## Abbreviations

The following abbreviations have been used in this document.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHS</td>
<td>Aboriginal Health Service</td>
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<tr>
<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
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<td>HMR</td>
<td>Home Medicines Review</td>
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<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<tr>
<td>PhIP</td>
<td>Pharmacist Incentive Payment (proposed initiative)</td>
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<tr>
<td>PNIP</td>
<td>Practice Nurse Incentive Program</td>
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<td>PSA</td>
<td>Pharmaceutical Society of Australia</td>
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<tr>
<td>QUM</td>
<td>Quality use of medicines</td>
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<tr>
<td>SWPE</td>
<td>Standardised Whole Patient Equivalent</td>
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A day in the life of a clinic pharmacist

As I enter the clinic, the waiting room is overflowing and I know it is going to be another busy day. Whilst logging on to Medical Director (MD) and sipping on a coffee, Dr K asks me to develop a pain management plan for a palliative breast cancer patient she is visiting this morning.

Dr K wants the patient’s regimen to allow for easy up titration of dosage of opioids as required. The patient has had multiple recent visits to hospital so I read through all the progress notes, pathology and referral letters, and check the latest palliative guidelines. I type my recommendations into Medical Director, and catch Dr K between patients to discuss.

Next the nurse brings me a patient she is worried about. The patient has her pockets stuffed with her many medicines and is confused about whether she took her tablets this morning. After much talking and listening, the patient agrees that her medicines are important and that a Webster pack may be of some assistance. We phone the pharmacy and organise it. Fortunately the QUMAX program will fund the cost of her Webster packs.

The practice manager comes by and asks me to assist her with the QUMAX progress plan and report. I phone a couple of local pharmacies to discuss the changes we are making to the QUMAX contracts. Dr C drops in to check what dose of insulin he should start Mr S on and the medical student comes by to discuss his diabetes project.

My 10.30am appointment, Mrs R, has arrived with her son, James. I contacted Mrs R last week as the pharmacy told me that she had not been picking up her Webster packs. James explains that his mum has early stage dementia and she volunteers that she has not taken any medicines for about a month. I take Mrs R’s blood pressure. It is 210/145. I make an appointment for her to see the doctor. James agrees to pick up his mother’s Webster packs, but is still worried that his mother may forget to take her tablets. I make some recommendations for Mrs R’s medicines so that they will all be dosed in the morning. We organise for Mrs R’s granddaughter to visit her each morning to remind her to take her tablets.

In the lunch room, Dr J and I discuss which antipsychotics, anti-epileptics and mood stabilisers might decrease the effectiveness of oral contraceptives. I email her a list for future reference.

The home medication visit I was planning for the afternoon has cancelled. There has been a death in the community. It may be a couple of weeks until I get to see Aunty M. I am a little concerned that Aunty M has not had a lithium level done for two years so I ask the nurse to follow up and organise for Mrs M to have some pathology tests. The Aboriginal health worker brings one of his friends in for a yarn. Mr J tells me he is managing his medicines well, but is a bit tired and a cough is waking him up. I notice he has very swollen ankles. On looking at his history I see that he has chronic heart failure. I send him in to see the doctor, who orders him some frusemide.

It has only been a couple of months since I started working one day a week at the Aboriginal Health Service. Already I am becoming a valued team member. The patients have complex needs and the GPs struggle to have time to address all their issues in one consult. Having a team approach to patient management is the only way to manage the case load. Many of my patient interactions are opportunistic. Being part of the team, being able to discuss the patient with other health professionals, and being able to access Medical Director for a complete patient history, enables me to conduct meaningful, informed clinical interventions.

“There are very few Aboriginal health services and GP clinics which have a clinical pharmacist in-house.”

There are very few Aboriginal health services and GP clinics which have a clinical pharmacist in-house. The pharmacist’s role is a diverse one, including patient counselling around medication adherence, patient and health professional education, liaison with other pharmacists and health professionals, and decision making around medication choices. Although I am only in the clinic one day a week already I may have delayed or averted medical emergencies and hospitalisations. Salaried positions for pharmacists in these clinical settings would definitely save the Government health dollars.

One never knows what a day at the clinic will bring, but every day is challenging and rewarding. Now we just need the government to value the clinical pharmacists’ role and start funding pharmacist positions in Aboriginal health services.

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Integrating pharmacists into primary care teams

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