Guide to providing pharmacy services to Aboriginal and Torres Strait Islander people
Acknowledgments
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Endorsed by the Pharmaceutical Society of Australia Board [June 5, 2014]
This Guide can be located on the PSA website at www.psa.org.au
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Abbreviations

ACCHS  Aboriginal Community Controlled Health Services
AHS  Aboriginal Health Service
AHP  Aboriginal and Torres Strait Islander health practitioner
AHW  Aboriginal and Torres Strait Islander health worker
AHPRA  Australian Health Practitioner Regulation Agency
CTG  Closing the Gap
DAA  Dose administration aid
GP  General practitioner
IAHA  Indigenous Allied Health Australia
NATSIHWA  National Aboriginal and Torres Strait Islander Health Worker Association
NACCHO  National Aboriginal Community Controlled Health Organisation
NAIDOC  National Aboriginal and Islanders Day Observance Committee
NPS  NPS MedicineWise
PBS  Pharmaceutical Benefits Scheme
PSA  Pharmaceutical Society of Australia
QUM  Quality use of medicines
QUMAX  Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people
RAAHS  Remote Area Aboriginal Health Services

Glossary

Aboriginal Health Service: A primary healthcare service providing holistic health care to Aboriginal and Torres Strait Islander people. The term Aboriginal health service (AHS) refers to both government-funded and community-controlled health services. These services are sometimes also referred to as Aboriginal Medical Services (AMSs).

Aboriginal health practitioner: An Aboriginal or Torres Strait Islander person who assists Aboriginal and Torres Strait Islander people with their health, has Aboriginal and/or Torres Strait Islander Primary Health Care (Practice) Certificate IV and is registered with Australian Health Practitioner Regulation Agency (AHPRA).

Aboriginal health worker: An Aboriginal or Torres Strait Islander person who is part of a primary healthcare team assisting Aboriginal and Torres Strait Islander people with their health. In this Guide, the term Aboriginal health worker (AHW) includes persons with or without primary healthcare qualifications.

Cultural awareness: Raising the awareness and knowledge of individuals about the experiences of cultures which are different from their own.

Cultural competence: Cultural competence comprises four components: (a) awareness of one’s own cultural world view, (b) attitude towards cultural differences, (c) knowledge of different cultural practices and world views and (d) cross-cultural skills. Developing cultural competence results in an ability to understand, communicate with, and effectively interact with people across cultures.

Cultural respect: Cultural respect acknowledges that the health and cultural wellbeing of Aboriginal and Torres Strait Islander people, within mainstream healthcare settings, warrants special attention.

Cultural responsiveness: Refers to healthcare services or healthcare professionals who are responsive to the health beliefs, practices, culture and linguistic needs of Aboriginal and Torres Strait Islander people, families and communities.

Cultural sensitivity: An understanding of the legitimacy of difference and how own life experiences and realities impact others.

Cultural safety: Cultural safety is a commitment that the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal and Torres Strait Islander people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care. Cultural safety represents a shift from attitude to behaviour. It is determined by the Aboriginal or Torres Strait Islander person.

Medicine: A drug used for therapeutic purposes. The term medicine includes all dosages forms e.g. tablets, liquids, eye drops, inhaled drugs, injections, intravenous fluids.

Patient: Inclusive of the person receiving medical care and a nominated family or community member.
Scope

The Pharmaceutical Society of Australia (PSA) is committed to promoting quality use of medicines (QUM) in Aboriginal and Torres Strait Islander communities. The PSA recognises the need to improve the awareness and understanding of Aboriginal and Torres Strait Islander health and cultural issues amongst pharmacists and pharmacy staff. The PSA encourages pharmacists to develop relationships with Aboriginal and Torres Strait Islander people and communities in their local area to optimise health benefits to community members.

The Guide is designed to assist pharmacists to deliver a consistently high quality of service to Aboriginal and Torres Strait Islander people, to communicate effectively and to be culturally responsive health professionals. The Guide encourages increased engagement with Aboriginal health services (AHSs), key Aboriginal organisations and Aboriginal and Torres Strait Islander people.

The Guide includes an overview of Aboriginal and Torres Strait Islander specific medicine programmes and a resource list from which pharmacists can gather more in-depth information.

This document replaces the PSA Guidelines for provision of pharmacy services to Aboriginal and Islander health services (2005) and PSA An introduction to cultural orientation for participating pharmacists (2008).

About the document

The Pharmaceutical Society of Australia (PSA) is committed to promoting quality use of medicines (QUM) in Aboriginal and Torres Strait Islander communities.

It is important that pharmacists read this Guide in conjunction with the relevant Professional Practice Standards version 4, 2010 (www.psa.org.au/supporting-practice/professional-practice-standards/version-4), in particular:

Standard 1: Fundamental pharmacy practice

Standard 3: Counselling

Standard 15: Pharmacy services to Aboriginal and Torres Strait Islander health services.

Principles for engagement with Aboriginal and Torres Strait Islander people

The principles summarised below are discussed in detail throughout this Guide.

In all engagements with Aboriginal and Torres Strait Islander people, pharmacists and pharmacy staff should:

1. exhibit qualities of respect, reciprocity, equality and integrity
2. avoid being judgmental and/or making assumptions
3. be culturally responsive
4. communicate effectively
5. respect diversity
6. invest in positive relationships.
1. Introduction

Aboriginal and Torres Strait Islander people in Australia have a higher mortality, higher infant mortality, greater rate of hospitalisation, higher burden of disease, higher levels of trauma and grief and more social disadvantage than other Australians.¹

Whilst Australian Bureau of Statistics data shows that death rates of Aboriginal and Torres Strait Islander people are higher in remote and very remote areas than in urban and regional areas, social and health problems are not confined to remote communities.²

There is a clear relationship between the social disadvantages experienced by Aboriginal and Torres Strait Islander people and their current health status. These social disadvantages directly relate to dispossession and are characterised by poverty and powerlessness, and are reflected in education, employment and income.³ Racism and discrimination are directly associated with poorer health outcomes.⁴ Ill health for Aboriginal and Torres Strait Islander people is more than physical illness; it is a manifestation of spiritual and emotional alienation from land, family and culture.⁵ Conversely, the sense of belonging to community and to land positively impacts health and wellbeing for most Aboriginal and Torres Strait Islander people.

Aboriginal and Torres Strait Islander health is defined as not just the physical wellbeing of an individual. It refers to the social, emotional and cultural wellbeing of the whole community where each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.⁶

For further information about Aboriginal health and AHSs and the role of AHWs, see Section 7: Background information.
2. Understanding culture

Culture is central to how a person views the world, how a person views themselves and others. It is useful, before trying to understand the culture of others, to reflect on one’s own. Self-reflection about one’s own culture, biases and tendency to stereotype helps to gain a better understanding of diversity of values, beliefs and behaviours.

Irrespective of training and experiences the key concern is how the health professional responds to any encounter with person, family or community. Culturally responsive care is the extension of patient-centred care that includes particular attention to social and cultural factors. It requires a health professional to continuously self-reflect and proactively respond to the person, family or community with whom they interact.

Health professionals need to be both clinically competent and culturally responsive to positively affect the health and wellbeing of Aboriginal and Torres Strait Islander people.

Local culture

Aboriginal and Torres Strait Islander people have many Nations, and thus many cultures. There are many cultural awareness courses available online which help with the appreciation of Aboriginal and Torres Strait Islander history (see Section 8: Resources). However, to learn the culture of local groups, often known as ‘mobs’, engagement with local Aboriginal communities is essential. Some local organisations such as the AHS, the Land Council or regional Primary HealthCare Organisations (PHO) may offer localised cultural awareness training.
Cultural awareness or orientation training is only a starting point. To begin to learn about local culture, proactively engaging with Aboriginal or Torres Strait Islander people is necessary. Understanding principles of respect and reciprocity are essential for relationship building which is so important in enabling the delivery of culturally-responsive health care.

Pharmacists and pharmacy staff should undertake self-assessment to identify the learning needed to ensure they provide culturally-responsive health care. All pharmacy staff should reflect on their own culture and ask how their behaviours are influenced by their culture. Staff should be asked to consider family, food customs, spiritual beliefs, connections to place, social practices and community interactions. Pharmacists need to take on a leadership role with their staff in this area.

Pharmacy staff induction should include learning about the local community and completing a community cultural orientation checklist (see Appendix 1: Community cultural orientation checklist).

Respect

Cultural respect is the recognition, protection and continued advancement of the rights, cultures and traditions of Aboriginal and Torres Strait Islander people. A pharmacist can show respect by learning about Aboriginal and Torres Strait Islander culture, listening actively, consulting on issues and avoiding stereotyping Aboriginal and Torres Strait Islander people (see Section 3: Engaging with Aboriginal and Torres Strait Islander organisations).

Shame

Many Aboriginal and Torres Strait Islander people may be shy and feel ‘shame’ if embarrassed or singled out. The feeling of shame is heightened for Aboriginal and Torres Strait Islander people. Shame can totally overwhelm and disempower a person. Sometimes, just being sick makes Aboriginal people feel shame and pharmacists should be aware of this feeling. Actions such as discussing a person’s health in public, berating a patient for medicine non-adherence and assuming literacy can all cause shame.

Family and community

In most Aboriginal cultures, family is extremely important. Aboriginal patients’ families and carers play an important role in assisting patients to manage their health and medicines. Aboriginal and Torres Strait Islander people tend to have extended families and these often go beyond blood and marriage. Relatives, even though not blood related, may be called Aunty or Uncle and may have responsibilities for the extended family. These extended family groupings may result in multiple adults participating in the rearing of children. Complex kinship systems may define where a person fits into the community and what rights and responsibilities they have within that community.

Often a nominated family member, rather than the patient, will make healthcare decisions. It is important for pharmacists to have an understanding of which family members need to be included in shared clinical decision making or to ask if other family members need to be involved.

Elders

An Elder is a member of the community who is respected and has the permission and authority within the community to give advice and pass on knowledge. Elders are usually the holders of traditional knowledge and customs. The term ‘Elder’ may or may not refer to men or women over the age of fifty or sixty years. Young people may be given permission to talk on behalf of an Elder. Pharmacists should be aware of addressing an Elder in the appropriate way. Some Elders are referred to as Uncle or Aunty, but these titles can only be used when given permission to do so. Simply asking is the best way to find out the most appropriate title.

Men’s and women’s business

In Aboriginal and Torres Strait Islander culture, certain customs and practices are performed separately by men and women. These are often referred to as men’s business and women’s business. Some information may only be talked about, negotiated and consulted on by either men or women. This is especially true for sexual health matters.

Gender equity is preferable for many Aboriginal and Torres Strait Islander people when discussing health issues. If a pharmacist or pharmacy staff member of the same gender is not present in the pharmacy, it may be important to find an AHW of the appropriate gender to assist with health discussions.
Sorry business

Sorry business is a term used by Aboriginal and Torres Strait Islander people to refer to the death of a family or community member and the mourning process. Sorry business may include attending funerals and taking part in mourning activities with the community and can take an extended period of time and may also involve travelling long distances. It is important in Aboriginal and Torres Strait Islander cultures that people participate in sorry business. In many communities, it is common practice not to mention the name of a deceased person or show pictures of them for some time after they have passed away. Local customs and protocols around sorry business may vary between communities, therefore it is important to learn about and understand the protocols of your local community.

Traditional owners

Aboriginal and Torres Strait Islander people are the traditional inhabitants and owners of Australia. Aboriginal and Torres Strait Islander people have a spiritual link with the land which provides a sense of identity, and lies at the centre of their spiritual beliefs. The term ‘country’ is often used by Aboriginal and Torres Strait Islander people to describe family origins and associations with particular parts of Australia. Loss of connectedness to land through dispossession has influences on Aboriginal and Torres Strait Islander people’s physical and social wellbeing.

At formal gatherings of the broader community, it is respectful to acknowledge the traditional owners of the land. Local Aboriginal or Torres Strait Islander organisations can advise on the most appropriate way to do this.

Terminology

It is not appropriate to use the words ‘Aborigine’ or ‘Aborigines’ as they imply all Aboriginal people are the same. The term ‘Aborigine’ is also associated with the periods of colonisation and assimilation. Instead, the terms ‘Aboriginal’ or ‘Aboriginal and Torres Strait Islander’ should always be used as an adjective rather than a noun and always capitalised. The term, ‘Aboriginal’ is used alone only when it is known that the person has no Torres Strait Islander descent. Otherwise always use Aboriginal and Torres Strait Islander person.

Examples:
- ✓ Jo is an Aboriginal woman.
- ✗ Jo is an aboriginal woman.
- ✗ Jo is an Aboriginal.
- ✗ Jo is an Aborigine.

The abbreviation ‘ATSI’ is considered disrespectful when used as an adjective. It may be used as part of a larger acronym e.g. NATSIHWA.

Examples:
- ✓ Aboriginal and Torres Strait Islander person/family/community.
- ✗ ATSI person.

Pharmacists should ask their local community how they like to be addressed. There are a number of names that vary with locality such as Koori, Murri, Goorie, Nunga and Yolngu. Find out the appropriate name for people in the local region.

Although the term Indigenous is used by many Government departments, it is not favoured by many Aboriginal and Torres Strait Islander people as many feel the term is non-specific and therefore diminishes their identity. The term Indigenous should not be used if at all possible. If it is used, ensure that it is spelt with a capital ‘I’.

Terms such as full-blood, half-caste, quarter-caste and quadroon are extremely offensive, as is the term part-Aboriginal, and they should never be used. Never ask an Aboriginal and Torres Strait Islander person a question to quantify their Aboriginality.
3. How to build relationships

Establishing trust through the building of relationships is essential to the delivery of effective health care. Personal relationships need to be built with the individual, appropriate family members and the community before a professional or clinical relationship can be established.

For a pharmacist to build relationships:

- Understand Aboriginal and Torres Strait Islander identity. People who identify themselves as Aboriginal and Torres Strait Islander range from dark-skinned to blonde-haired, blue-eyed people. Aboriginal and Torres Strait Islander people define Aboriginality not by skin colour but by relationships. Referring to someone as part-Aboriginal is extremely offensive. Aboriginal or Torres Strait Islander identity for Government programmes requires:
  - a person to be of Aboriginal and/or Torres Strait Islander descent
  - a person to identify as an Aboriginal and/or Torres Strait Islander person
  - a person to be accepted as an Aboriginal and/or Torres Strait Islander person by the community in which they live.
- Get to know the local Aboriginal or Torres Strait Islander community. Establishing trust and credibility is vital. Arrange appointments to meet the local Aboriginal and Torres Strait Islander land councils, community organisations, health services, education units of local universities and TAFEs, Aboriginal and Torres Strait Islander project officers at Primary Health Networks (PHN) and attend local Aboriginal and Torres Strait Islander community events.
- Respect diversity amongst Aboriginal and Torres Strait Islander communities. Every community will have common ground and similarities, but also different issues. There are different traditions and customs, different ways of communicating, different understandings, different sensitive issues, different Elders, and different levels of education and health literacy, within one community.
- Consult with the Aboriginal and Torres Strait Islander community sincerely. Face-to-face consultation is a preferred way of engaging and communicating. Communities and individuals should be consulted and asked for permission before implementing new health programmes or strategies. Engage with local communities by offering education and health promotion, and informal meetings at the pharmacy over a cup of tea.
- Communicate effectively using respect, active listening, patience, understanding, plain language, confirmation, clarification and feedback (see Section 4: How to communicate). In some communities, English is not the first language and a translator may be needed.
- Maintain constant contact and work in partnership with the patient/community. This is essential. It keeps both parties informed, up-to-date and aware of any potential problems. It indicates that the pharmacist is interested and involved in outcomes. Endorse principles of respect, reciprocity, equality, responsibility and integrity in all dealings with individuals, community and organisations. Show leadership in these principles to other pharmacy staff and non-Aboriginal and Torres Strait Islander community members.
• Assist Aboriginal and Torres Strait Islander workforce development by employing Aboriginal and Torres Strait Islander pharmacy staff and encouraging students to undertake health studies (see Section 6: Aboriginal and Torres Strait Islander pharmacy programmes)
• Avoid being judgmental or making assumptions. Judgmental and racist attitudes are barriers to therapeutic relationships and are not always recognised by the pharmacist involved. Review pharmacy practices, and recognise and monitor personal cultural bias. Pharmacy team members need to include cultural competency in their professional development plans.
• Provide proactive leadership against racism by ensuring all team members are culturally responsive and that the practice/organisation has adopted systems/practices to ensure there is no organisational racism.
• Understand Aboriginal and Torres Strait Islander history, culture and current issues. The Australian public is often surrounded by detrimental stories that influence public opinion. Ensure that correct information is obtained (see Section 7: Background information).

Engaging with Aboriginal and Torres Strait Islander organisations

Building a relationship with local Aboriginal and Torres Strait Islander communities can often be best brokered through a local community organisation, such as an AHS. If a relationship with a local organisation is difficult to establish, a national organisation such as IAHA or National Aboriginal Community Controlled Health Organisation (NACCHO) can assist.

Once rapport with local Aboriginal and Torres Strait Islander organisation staff members has been established, pharmacists can ask for assistance in learning more about the local community by asking questions, such as:
• Who are the best people in the community to help me learn more about local culture? Can you please assist me to meet with them?
• Are there programmes/services that I can assist with in the community?
• What have been the main challenges and successes for the community (social and health)?
• What language do most people in the community speak? Are interpreters available?
• What health services are available for Aboriginal and Torres Strait Islander people?
• Do people in this area still use bush medicines?
• How can I better assist Aboriginal and Torres Strait Islander people in the community to manage their medicines?
• Who is the best person within your organisation for me to contact?

Pharmacists could offer services such as staff training about medicines, health promotion activities and event sponsorship to their local AHS.

Examples of pharmacy health promotion activities a pharmacy may offer, after consultation with the AHS about community needs, include:
• diabetes screening (including blood glucose testing) during National Aboriginal and Islanders Day Observance Committee (NAIDOC) week
• blood pressure testing at football carnivals or art workshops
• healthy lifestyle talks/competitions at local schools
• smoking cessation talks at antenatal classes.

Visiting Aboriginal and Torres Strait Islander communities

Prior to visiting a community, a pharmacist needs to:
• understand population statistics and profiles. For information about age, gender, life expectancy, percentage of Aboriginal and Torres Strait Islander people, see www.abs.gov.au/AUSSTATS
• investigate history of the community
• identify key people who are respected in the community e.g. Elders, nominated and/or elected community representatives
• contact the AHS to confirm appropriateness of visitation dates (confirm the timing is acceptable and does not coincide with significant events within the community). Check which other health professionals are visiting and what community events are occurring
• obtain permit to visit lands, if needed
• phone the day before the visit in case of sudden events e.g. sorry business.

On the day of visit, a pharmacist needs to:
• ask the primary contact or AHW, ‘Is there anything happening within the community that I should be aware of?’; ‘Are there any particular areas where it is inappropriate to go?’
• ask what protocols need to be followed should a traumatic event occur e.g. death
• display appropriate sensitivity to cultural beliefs. These may include traditional healers, black magic, men’s and women’s business, smoking ceremonies etc. If someone has died, you may not be able to use that name for others with the same name
• consider the language to use. Avoid ‘over-talking’, use plain English, be specific. Keep volume of speech moderated
• ensure client confidentiality is maintained
• consider non-verbal communication. Downcast eyes can be culturally appropriate. Non-verbal communication is guided by the patient
• consider the clothing to be worn. Dress modestly. Polo shirts (uniform) are appropriate. Business clothes can be construed as authoritarian and may inhibit interactions
• if possible, allow additional time to meet community members or attend a community event, if appropriate
• complete the community cultural orientation checklist (see Appendix 2: Checklist for preparing for an AHS or community visit).

For examples of community visits, see Scenarios 4A & 4B.
4. How to communicate

Appropriate language during health consultations is important. Pharmacists should limit the use of medical jargon, but not assume poor patient understanding. Patronising language and tone should be avoided, as should speaking overly slowly or loudly (unless patient has a hearing impairment).

To achieve effective communication with all population groups, complex medication and health issues need to be explained in plain English, active listening needs to be practised and feedback around patients’ understanding needs to be sought. Use appropriate metaphors to explain concepts. These metaphors should be tested with AHWs or community members. Every consultation needs to be tailored to the patient’s needs.

Silence does not mean that the individual does not understand, but rather that they are listening and thinking. Taking time to respond can be a mark of respect. Allow for periods of silence.

Eye contact for many non-Indigenous and Aboriginal and Torres Strait Islander people is considered a key component of communication. However, for some Aboriginal and Torres Strait Islander people, looking someone straight in the eye may be considered rude or disrespectful. As there are variations across cultural groups, assumptions should not be made. Ask local Aboriginal and Torres Strait Islander organisations to clarify what is customary for the local area.

Some Aboriginal and Torres Strait Islander people may agree with all statements being made by the pharmacist. They may answer ‘yes’, regardless of whether they actually agree with or understand what has been said. Pharmacists should ask open-ended questions that do not have a ‘yes/no’ answer and seek feedback to ensure understanding of key messages.

Pharmacists should be aware of non-verbal communication and of the physical environment in which communication is occurring. Sitting beside a patient is more likely to result in two-way communication. It is acceptable to seek clarification and assistance from the patient or family when understanding or appropriate behaviour is not known.

In some communities, levels of literacy and education may be low. A pharmacist should not mistake this as low intelligence. Being creative and using visual diagrams and pictures may be helpful for patient understanding. Conversely, highly literate patients may be offended by being given pictorial resources. Communication techniques should be tailored to the patient.

If working with members of Aboriginal and Torres Strait Islander communities who lack literacy and numeracy skills, it may be necessary to offer assistance with completing forms, reading
information and writing statements. It is important to approach this sensitively and not cause embarrassment or shame to the person by asking them whether or not they can read or write.

In many communities, especially in remote areas, local Aboriginal or Torres Strait Islander language is spoken. An Aboriginal or Torres Strait Islander person may have English as their third or fourth language or may not speak English at all. Some people also use broken, Pidgin, Creole or Aboriginal English.

Interpretation by other family members or through an interpreter service may be needed. Be aware however that interpretation by a family member or AHW can result in miscommunication. It is useful to have a conversation with the interpreter to discuss concepts so they or a family member can work out appropriate metaphors and interpretation. If a pharmacist attempts to learn some key words or phrases in a local language, this would be well received as a true commitment to the local people.

Pharmacists should be aware that although an Aboriginal or Torres Strait Islander person does speak English, they may interpret words differently, especially around health and the body. Communicating through an AHW may offer the most effective communication strategy.

Constant negative health messages can result in poor health outcomes becoming normalised and expected. Emphasising wellness and sickness prevention, focusing on strengths and successes, may deliver better health outcomes.

Past experiences of personal racism and/or racist services may make patients hypersensitive to perceived racism in communication. Pharmacists are advised not to minimise or disregard any complaints or client concerns about cultural insensitivity, as it is the clients’ perception that will impact on communication, regardless of the pharmacist’s or pharmacy staffs’ intentions.

**Patient medicine counselling**

Pharmacists should tailor patient counselling and medication education to meet the needs of the individual. The counselling tips listed in Table 1 are based on Queensland Health Guidelines for Communicating Effectively with Aboriginal and Torres Strait Islander people. This is general information only (see Table 1).

**Communicating about medicines**

When communicating information about medicines, pharmacists should remember that medicines may only be one of many parts of the patient’s health care and may not be their priority. Establish how the patient is feeling about taking their medicines. Any barriers to medicine taking need to be identified before the patient can be successfully assisted with management of their medicines. Barriers need to be identified without asking the patient questions which will cause any embarrassment or shame. Discussion around treatment compliance can be unhelpful if it implies fault on the part of the patient. The patient must always be included in shared and informed decision making around medicine choices.

Be mindful of the following issues which may affect some Aboriginal people’s access to and management of medicines including:

- cost
- availability of transport
- availability of pharmacies
- lack of appropriate storage facilities – availability of refrigeration
- overcrowding – having no secure place to store medicines away from children
- low literacy levels may make reading labels and information difficult
- language differences may lead to misinterpretation of information
- low health literacy and differing views on health may lead to misunderstanding
- difficulty in navigating through the complex health system
- lack of understanding of a pharmacist’s role
- complex dispensing protocols and rules such as the PBS Safety Net 20 Day Rule, Closing The Gap (CTG) PBS Co-payment Measure
- heavy disease burden, heavy treatment burden
- personal health may be a low priority due to family commitments/stressors or other lifestyle factors.

There are many Aboriginal and Torres Strait Islander information resources to assist with patient counselling. The most comprehensive is The Medicines Book for Aboriginal and Torres Strait Islander health practitioners and health workers. This resource uses plain English language and pictures to explain indications, doses and adverse effects for the most common drugs (see Section 8: Resources).

Pharmacists should assist patients to understand the duration of their therapy. They should provide patients with appropriate written and pictorial resources, which they can take home to read and discuss with other family members. Understanding the purpose and duration of therapy is especially important in diseases where patients may perceive no illness and no effect from medicines, such as high blood pressure, glaucoma and elevated cholesterol.

Medicine identification is also important and pharmacists should consider providing patients
### Things to consider

<table>
<thead>
<tr>
<th>HOW AND WHY</th>
<th>THINGS TO CONSIDER</th>
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<tbody>
<tr>
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<td>Remember the past</td>
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<tr>
<td>Is the counselling space culturally welcoming &amp; safe?</td>
<td>Environment</td>
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<td>A smiling greeting or acknowledgment is important</td>
<td>Welcome</td>
</tr>
<tr>
<td>Be warm &amp; welcoming</td>
<td>•</td>
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<tr>
<td>Spend time building rapport before getting down to business</td>
<td>Relationships first</td>
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<td>Speak in gentle tones</td>
<td>Tone of voice</td>
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<tr>
<td>Don’t speak too fast</td>
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<td>Don’t be patronising</td>
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<tr>
<td>Speak to the right person</td>
<td>Who</td>
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<td>Is there a need to invite other family or community members to be present?</td>
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<tr>
<td>For example:</td>
<td>•</td>
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<tr>
<td>- Are you happy talking to me about your health?</td>
<td>-</td>
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<tr>
<td>- Would you like anyone else to be with you?</td>
<td>-</td>
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<tr>
<td>Does the patient speak English?</td>
<td>English language</td>
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<td>Is there a need for a family member, an interpreter or Aboriginal health worker to interpret?</td>
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<td>If the patient is of different gender, the patient may not wish to discuss their health issues</td>
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<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- Would you like to talk to the man pharmacist, instead of me?</td>
<td>-</td>
</tr>
<tr>
<td>- Would you like to invite a male health worker to be here too?</td>
<td>-</td>
</tr>
<tr>
<td>- May I speak to you about…?</td>
<td>-</td>
</tr>
<tr>
<td>Do not shame the patient by discussing their health issues in spaces that are not private</td>
<td>Confidentiality</td>
</tr>
<tr>
<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- Let’s go over to the counselling desk so that we can talk about your medicines</td>
<td>-</td>
</tr>
<tr>
<td>Allow plenty of time to ensure proper counselling can occur</td>
<td>Time</td>
</tr>
<tr>
<td>Direct questioning can be confronting</td>
<td>Questioning</td>
</tr>
<tr>
<td>Make sure it is a two-way exchange</td>
<td>•</td>
</tr>
<tr>
<td>Do not ask the patient to keep repeating themselves</td>
<td>•</td>
</tr>
<tr>
<td>Ask open ended questions</td>
<td>•</td>
</tr>
<tr>
<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- How are you going with these medicines?</td>
<td>-</td>
</tr>
<tr>
<td>Ensure active listening</td>
<td>Listening</td>
</tr>
<tr>
<td>Do not interrupt or speak over the patient</td>
<td>•</td>
</tr>
<tr>
<td>Take turns to speak</td>
<td>•</td>
</tr>
<tr>
<td>Do not fill in silences</td>
<td>•</td>
</tr>
<tr>
<td>Do not use jargon, without explanation</td>
<td>Sharing knowledge</td>
</tr>
<tr>
<td>Use diagrams, pictures, appropriate metaphors</td>
<td>•</td>
</tr>
<tr>
<td>Use plain English</td>
<td>•</td>
</tr>
<tr>
<td>Did the doctor tell you about this medicine?</td>
<td>For example:</td>
</tr>
<tr>
<td>This medicine is to help your heart to pump the blood around your body. It opens up the blood vessels and helps the blood to flow easier. I have a diagram here I will show you. It will help prevent you getting sicker</td>
<td>-</td>
</tr>
<tr>
<td>What else would you like to know about this medicine?</td>
<td>-</td>
</tr>
<tr>
<td>You need to take one tablet when you get up in the morning</td>
<td>-</td>
</tr>
<tr>
<td>You need to take it every day</td>
<td>-</td>
</tr>
<tr>
<td>You need to keep taking it</td>
<td>-</td>
</tr>
<tr>
<td>Ask an open-ended question which checks that the patient understands the concept just explained but don’t cause shame</td>
<td>Check understanding</td>
</tr>
<tr>
<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- So, when will you take this tablet?</td>
<td>-</td>
</tr>
<tr>
<td>Provide patient with clear choices</td>
<td>Decision making</td>
</tr>
<tr>
<td>Patient needs to be involved in goal setting</td>
<td>•</td>
</tr>
<tr>
<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- As your blood pressure is high and your heart is working too hard, do you think it is a good idea to take this tablet to help your heart?</td>
<td>-</td>
</tr>
<tr>
<td>- How do you feel about taking this tablet?</td>
<td>-</td>
</tr>
<tr>
<td>Always seek advice if you are not sure what to say or do</td>
<td>Seek advice</td>
</tr>
<tr>
<td>Admit limited knowledge</td>
<td>•</td>
</tr>
<tr>
<td>Be prepared to make mistakes</td>
<td>•</td>
</tr>
<tr>
<td>For example:</td>
<td>•</td>
</tr>
<tr>
<td>- I am not sure I have explained that very well. Shall I ask the health worker to come and help me?</td>
<td>-</td>
</tr>
</tbody>
</table>
with medicine lists which identify tablet shapes and colours, when appropriate.

Be mindful of the patient’s understanding of terminology. The word ‘medicines’ may be interpreted as only liquid medicines by some and thus not include tablets, inhalers etc. Words such as heart, mind, blood may also have different meanings from western medical interpretation. Receiving feedback to ensure key messages have been understood is crucial.

Local AHWs can be a valuable resource to assist in using the most appropriate counselling techniques and language.

**Assisting medicine adherence**

To improve medicine adherence, pharmacists should provide the patient with information about the medicine’s mode of action, indication and adverse effects. By providing information about risks and benefits of medicines, pharmacists can empower patients to make informed decisions and set goals around their medicine taking.

Inherent and specific barriers to medicine taking cannot be overcome in one or two conversations. There needs to be an ongoing dialogue between the patient and pharmacist. The pharmacist needs to understand the patient’s belief systems around the concept of medicine taking and western-style health care and their understanding of their condition and disease management. Pharmacists should be aware that some Aboriginal and Torres Strait Islander people may use traditional healing methods and bush medicine.

To ascertain the level of patient medicine adherence, the pharmacist may wish to ask the following open questions, such as:

- How are you managing your medicines?
- How do you take your medicines?
- How often do you take them?
- It is easy to forget. Do you sometimes forget? Have you taken your tablets today? Which medicines do you not like taking?
- Do you know how many medicines you take each day?
- Taking medicines can be confusing. How many do you take?
- What would you like to know about your medicines? Do you have any questions?
- Is there someone who helps you with your medicines? Would you like me to talk with them?

If a patient is non-adherent, ascertain if this is intentional or non-intentional. If non-intentional, suggest some strategies to assist such as using a calendar, alarm, phone application, seeking the help of a family member or AHW or using a dose administration aid (DAA). NPS MedicineWise (NPS) has a free smartphone application which has a medicine list plus an alarm to remind patients to take their medicines. For more information about this phone application, see [www.nps.org.au/topics/how-to-be-medicinewise/managing-your-medicines/medicines-list/medicinelist-smartphone-app](http://www.nps.org.au/topics/how-to-be-medicinewise/managing-your-medicines/medicines-list/medicinelist-smartphone-app)

If a patient is intentionally non-adherent, ascertain the barriers and address them. For example, is it cost, lack of understanding or fear of taking too many medicines? Or perhaps the patient is experiencing side effects. Provide the patient with knowledge about their medicines which will assist them analyse the risks and benefits and make an informed choice. A Home Medicines Review may assist to ascertain if side effects or drug interactions are impacting adherence.

**Medicine labelling and directions**

Pharmacists and pharmacy staff should analyse the directions written on dispensing labels, and assess what they might mean to the patient. For example, what does ‘one twice daily’ mean to the patient, what does ‘one with meals’ mean when the patient doesn’t have regular meals and what does ‘5 mL’ mean to someone who has no measure? For low literacy patients, a pharmacist may use sun and moon labels, but do not assume that all people will attach the same meaning to these pictures.

Take time to assess what is needed. Below are some issues to consider, which may need discussion with the patient:

- **One twice a day** may be better expressed as 1 tablet in the morning and 1 tablet at night.
- **One daily** may be better expressed as one in the morning.
- **Take with food** may be better expressed as taking it with a meal or snack is best.
- **5 mL** may be better expressed as measure up to the mark (on marked measuring spoon or syringe).
- **Have with your tea** may be better expressed as have with food at night (tea usually means a cup of tea, so don’t tell someone to take one tablet with tea (meaning dinner) as this may mean they have one tablet with each cup of tea).
5. Providing pharmacy services

The Australian health system is complex and difficult to navigate. People with high levels of chronic disease often need to access a large number of health professionals and may have to access medicine services from a variety of providers including doctors, nurses, and AHWs.

Pharmacists can play an important role in assisting patients access the care they require. Pharmacists should encourage patients to register for and utilise electronic health records. There is often a poor level of understanding of the role of a pharmacist or the services a pharmacy may be able to provide.

Improving cultural safety in the pharmacy

A culturally safe environment is one in which people feel comfortable and respected. To make a pharmacy more culturally safe for local Aboriginal and Torres Strait Islander people, pharmacists should seek the advice of local community members as to how the pharmacy can be made more welcoming.

A culturally safe pharmacy may include:

- a sign that welcomes Aboriginal and Torres Strait Islander people or flags and local artwork
- health resources specifically written for Aboriginal and Torres Strait Islander people
- a private area to discuss medicines
- staff who attend community events (e.g. NAIDOC week)
- sponsorship of local Aboriginal and Torres Strait Islander teams, events or individuals
- employment of Aboriginal and Torres Strait Islander people (financial incentives can be attained for employing Aboriginal staff under the Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship Scheme, see 5cpa.com.au/programs/aboriginal-and-torres-strait-islander-initiatives/aboriginal-torres-strait-islander-pharmacy-assistant-traineeship-scheme)
- a sign, poster or video to inform patients of services offered at the pharmacy
- culturally responsive staff. Pharmacies should adopt a position statement that addresses cultural responsiveness and discuss it with all staff. Often it is the pharmacy staff who engage most frequently with patients and so all pharmacy staff should undertake cultural awareness training. Cultural responsiveness should be an important component of staff performance management reviews.

Pharmacy services

Medicine management

Pharmacists play an important role in assisting patients to understand their medicines and make medicine choices. Pharmacists need to assist patients with practical solutions around safe storage of medicines, as well as giving information to patients about correct dosing, monitoring and duration of therapy. Pharmacists need to be mindful
that some patients may live in crowded households, with many children and no refrigeration.

Pharmacists should emphasise positive outcomes and explain risk reduction, as well as notifying patients of the possible adverse effects, related to their medicines. Many patients cease medicines because of the perception that the medicine is not making any difference, lack of understanding of the need for ongoing medicine or because of adverse effects. Pharmacists should assist patients to understand the benefits of long-term therapy when appropriate (see Section 4: How to communicate).

**Medicine education**

Pharmacists should partner with AHSs to provide medicine education to AHS staff as well as to community groups and patients. There are opportunities for pharmacists to become involved in primary healthcare programmes and health promotion activities being implemented by the AHS. Pharmacists should consider linking with Aboriginal program managers at Primary Healthcare Organisations PHOs who can facilitate education and resources for patients.

In rural and urban locations, funding is available through the Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander people (QUMAX) programme for pharmacists to deliver medicine education (see Section 6: Aboriginal and Torres Strait Islander pharmacy programs). In remote areas, S100 Pharmacy Support Allowance funding may be used for medicines education.

**Medicine lists**

A medicine list that records a patient’s medicines, indications and doses is extremely useful in assisting patients who have to attend hospitals, medical specialists, a variety of primary care settings, and when travelling. Especially useful are lists which include pictures showing the appearance of tablets. A number of software programmes include pictures for tablet identification.

Pharmacists should ensure medicines lists are kept up-to-date. NPS provides a hard copy medicine list. Patients can also use blister pack (e.g. Webster-pak) cards or hospital discharge charts to record their medicines. There are a number of smart phone applications which also can record medicines. For more information about NPS MedicinesList and smartphone app, see [www.nps.org.au/topics/how-to-be-medicinewise/managing-your-medicines/medicines-list/medicinelist-smartphone-app](http://www.nps.org.au/topics/how-to-be-medicinewise/managing-your-medicines/medicines-list/medicinelist-smartphone-app)

**Community pharmacy services**

Dispensing protocols, the lack of relationships with pharmacists, and the physical settings of community pharmacies are sometimes barriers for Aboriginal and Torres Strait Islander patients accessing community pharmacy.11–15 Many patients do not understand the PBS Safety Net 20 Day Rule, the CTG prescription rules and Pharmaceutical Benefits Scheme (PBS) safety net thresholds. Patients from remote areas, used to obtaining subsidised medicines under the Remote Area Aboriginal Health Services (RAAHS) programme, may not understand the need for prescriptions, Medicare cards and payment when visiting an urban area. Pharmacists need to assist patients to navigate the system without causing shame to the patient and whilst trying to build a relationship. Respect and trust are essential to medication management and therapeutic goal setting.

**MedsCheck/Diabetes MedsCheck**

A MedsCheck or Diabetes MedsCheck service provides a valuable opportunity for a patient to have a medication review in the pharmacy (see PSA Guidelines for pharmacists providing medicines use reviews (MedsCheck) and diabetes medication management (Diabetes MedsCheck) services). Pharmacists need to ensure patients understand the review process and provide consent to participate in the review. The review must be conducted in an area of the pharmacy which provides patient privacy. Medicine counselling should include appropriate language and communication (see Section 4: How to communicate).

**Dispensing generic medicines**

Aboriginal and Torres Strait Islander people, like other populations, find generic brand substitution very confusing due to the varied tablet appearances and different names. A pharmacy should remain consistent with their generic brands wherever possible. All brand changes should be clearly communicated to patients. The decision about brand is a patient’s choice. If the brand of the medicines bulk supplied to a remote area AHS is changed, the AHS staff should be notified and assistance provided to help staff and patients understand the change, especially if the colour or shape of the tablet has changed.

Pharmacists need to be aware that some Aboriginal and Torres Strait Islander people may have a preference for the branded medicine and are prepared to pay the premium for the more expensive product. It is important to ask the patient’s preference before dispensing a particular brand or generic medicine.16
Scenario 1A: Example of poor community pharmacy engagement

Mr Q is the pharmacist at Pharmacy Y, a very modern pharmacy that has lots of cosmetics and perfumes, but no signs that welcome local Aboriginal people.

Mrs W, a Wiradjuri woman, visits Pharmacy Y. The staff are not friendly and keep talking amongst themselves as she approaches the counter. She presents a prescription for two antihypertensive medicines from a GP who has just recently joined a local practice. The pharmacist, Mr Q, does not notice that the prescription has no CTG annotation.

The prescription is dispensed and a staff member asks Mrs W for $60. Mrs W explains that she usually only pays about $5 a prescription. The pharmacy assistant continues to say that Mrs W will need to pay $60 unless she has a concession card. Mrs W explains that she is an Aboriginal person and gets CTG scripts. The staff member looks at her blankly. Eventually Mr Q becomes involved and says that she will have to take the script back to the doctor and get it correctly annotated.

Mrs W is not happy. She needs to get home to care for her elderly father and her sister's three children for whom she is the primary carer. She asks Mr Q if it would be possible for him to phone the doctor. Mrs W hears Mr Q on the phone to the doctor's surgery explaining how he has Mrs W in the pharmacy but she doesn't want to pay for her medicines. Mrs W feels shame. Mr Q talks to her about her medicines from the dispensary whilst he re-dispenses her CTG script. Mrs W feels shame. She doesn't hear what Mr Q is telling her. She just wants to go home. She doesn't really know why the doctor has prescribed all the tablets anyway. She will not come to this pharmacy again and will tell others that they don't like black fellas in Pharmacy Y.

Scenario 1B: Culturally responsive community pharmacy

Pharmacy X is a community pharmacy that proudly displays a poster advertising NAIDOC week celebrations in their town, and a certificate of appreciation from the local Aboriginal AFL team which they sponsor.

Mrs W, a Wiradjuri woman, visits Pharmacy X and is warmly greeted by all staff members. She presents a prescription for two antihypertensive medicines from a GP who has just recently joined a local practice. The pharmacist, Mr P, notices that Mrs W has previously had one of these medicines before and usually has her prescription CTG annotated. However, this prescription has no annotation. Mr P phones the doctor (privately where he can't be overheard) and explains the CTG system to the doctor. He organises to have the prescription annotated at a later date.

The prescription is dispensed by the pharmacy staff and then Mr P counsels Mrs W about her medicines. He greets Mrs W warmly and asks about her family. He ushers her to a private counselling area and inquires whether she is happy to have him talk to her about her medicines. Mrs W is keen to hear about her medicines and, finding Mr P respectful, agrees to talk about her medicines. Mr P explains what the medicines are for, how to take them and what adverse effects to look for. He explains the benefits and risks of the medicines in easy-to-understand language. He shows her a diagram of a blood vessel and a heart. He gives her some information to take home.

Mrs W feels quite satisfied with her visit to Pharmacy X.
Diabetes and asthma supplies

Pharmacists should encourage patients with diabetes to register for the National Diabetes Services Scheme (NDSS). The NDSS aims to ensure people have timely, reliable and affordable access to the supplies and services they require to effectively self-manage their diabetes. The NDSS subsidises blood glucose testing strips and insulin needles. For further information, see www.ndss.com.au

Pharmacists should be aware that the Asthma Spacer Ordering System (ASOS) provides low-cost spacers and masks to ACCHS. For further information, see www.asthma.org.au/Programs/AsthmaSpacerOrderingSystem

Distance supply

When medicines have to be transported or mailed to a remote patient, there may be little or no direct interaction between the pharmacist and the patient. Pharmacists should implement adequate systems to ensure medicines are securely delivered and that the patient receives sufficient information and advice to enable safe and efficacious use of the medicines. Use of technologies such as telephones, computer interfaces (e.g. Skype) and videoconferencing are recommended to enable interaction with the patient. An occasional face-to-face interaction is important to establish a relationship which will increase the effectiveness of subsequent distance communication.

Dose administration aids

There is a lack of research data to properly evaluate the benefits of dose administration aids (DAAs). However, clinical experience does suggest that DAAs, including dosettes, blister packs and multi-dose sachets, may assist selected patients better manage complex medication regimens.

Although DAAs are not appropriate for all patients, they can be a valuable adherence tool when the patient is motivated, willing to take their medicines and has adequate vision, cognition and dexterity to use the device. A blister pack DAA may be included as part of an overall strategy if the patient is having difficulty managing their medicines. If a patient is not collecting their DAAs, the pharmacist should follow up with the family, the doctor or the AHS.

There have been limited evaluations of sachet-dosing systems and some evidence suggests that the benefits of sachet packing on improving adherence are minimal.\(^7\) Sachets do not allow the patient or health professional to easily assess what medicines have or have not been taken. However, sachets are compact and are preferred by some patients. Dosette containers are not favoured in many settings as medicines can easily be mixed up.

The cost to patients of DAAs can be subsidised through QUMAX and CCSS (see Section 6: Aboriginal and Torres Strait Islander pharmacy programmes).

Under the Fifth Community Pharmacy Agreement 2010–2015 (SCPA), eligible community pharmacies are entitled to claim incentive payments for the provision of DAAs for patients who reside in the community and when DAAs are dispensed and packed in accordance with relative quality standards. For further information, www.5cpa.com.au

As blister packs for multiple patients may all be similar in appearance, the use of photo identification on each DAA could add improved safety especially in households where there are a number of persons using similarly packed medicines.

Medicare assistance

A dedicated telephone service, Medicare Aboriginal and Torres Strait Islander access line, has been established for Aboriginal and Torres Strait Islander people, and their service providers to assist with information about the Medicare Benefits Schedule, PBS and Medicare numbers. The toll free phone service is available on 1800 556 955. For further information, see www.humanservices.gov.au/customer/subjects/medicare-services-for-indigenous-australians

Hospitals and pharmacy services

Hospitals can be uncomfortable and confronting places for Aboriginal and Torres Strait Islander people. Past racism, death of a relative or friend and fear of government institutions may contribute to the discomfort. The burden of paperwork during their admission, the lack of understanding of extended family groups and the scarcity of Aboriginal or Torres Strait Islander staff, may also make Aboriginal and Torres Strait people feel unwelcome.

Some hospitals are now trying to address issues of organisational racism by running cultural awareness training for staff and employing Aboriginal liaison officers (ALO). ALOs can act as cultural brokers assisting with making the patient and family members feel more comfortable, developing a better understanding of a patient’s social situation, and facilitating communication. Some hospitals also have access to an Aboriginal language interpreter service which can greatly assist in coming to a shared understanding of the treatment choices available and facilitate informed consent.

Pharmacists working or providing services in a hospital setting should actively use the ALO and translator services where available as decision making about patient care and medicines may require consultation with nominated family members.
Scenario 2A: Organisational racism

It is the weekend and Mrs W’s father, Bob, a Wiradjuri Elder, is very sick. She takes him to the emergency department of the hospital, 100 km from her home town. Her father is asked to fill out lots of forms. The staff members are not helpful. He is shamed as he cannot read or write. Mrs W helps fill out the paperwork but does not know all her father’s details. He does not know his birth date or have a birth certificate. Bob is well respected and many of the community and family come to the hospital emergency department. When he is admitted, the family are not allowed to enter the emergency department or see the doctor. Many of the community members do not have transport, so some stay overnight in the waiting room. After a few days and lots of scary tests, Bob is diagnosed with having chronic heart failure. He is given many different medicines and is told to go home and see his GP. A pharmacist comes to see Bob before he is discharged. The pharmacist explains to Bob how to take his five new tablets. Bob cannot remember all the information the pharmacist has given him. He still does not understand about heart failure. He wonders why, if his heart has failed, he is still alive.

Bob can’t get an appointment with the GP in his town for about three weeks. He thinks he will just try being healthy. He doesn’t want to take all those tablets.

Bob continues to be very tired and unwell but refuses to go back to hospital. He is eventually readmitted three months later in a critically ill condition.

The hospital in this scenario could be accused of organisational racism as it did not address the needs of Bob and his family. The hospital could have assisted Bob by arranging an Aboriginal Liaison Officer (ALO) to speak to Bob and his family and to ensure that some transitional care arrangements were implemented to assist Bob to understand and manage his heart failure.

Scenario 2B: Culturally sensitive organisation

It is the weekend and Mrs W’s father, Bob, a Wiradjuri Elder, is very sick. She takes him to the emergency department of the hospital, 100 km from her home town. Her father is asked to fill out lots of forms. The hospital staff members are respectful and caring. They organise an ALO to assist Bob and Mrs W fill out the paperwork. Mrs W’s father is a respected community Elder so many people from the community and family come to the emergency department. The ALO arranges for significant family members to have access to the emergency department and explains to the doctor that these family members need to be included in health discussions. Many of the community members do not have transport, so the ALO makes arrangements for them to stay at a nearby hostel, reassuring them that he will phone if there is any news.

The ALO explains to Bob that he needs to have a number of tests. When Bob is diagnosed with having chronic heart failure, the ALO uses the Heart Foundation, *Living Everyday with my Heart Failure* (a pictorial resource produced especially for Aboriginal and Torres Strait Islander people), to explain to Bob, Mrs W and other family members what heart failure is, how Bob should manage his diet and fluid intake and why Bob has been given a number of different medicines.

The hospital pharmacy arranges for a pharmacist to see Bob and his family members before he is discharged. The ALO also attends. The pharmacist spends time with Bob and his family discussing what the medicines are for, how they work and how they should be taken. He shows Bob the information about his medicines in the *Medicines Book for Aboriginal Health Workers* and prints out a medicines list with pictures of the tablets. The pharmacist enquires about what arrangements Bob has to see his GP and medicines when he goes home. When Bob states that he will probably be unable to get an appointment with the GP in his town for about three weeks, the pharmacist organises for Bob to be discharged with a month’s supply of medicines. He emails the discharge summary to Bob’s nominated GP and community pharmacy.

Bob’s daughter assists her father manage his diet and fluid intake. Bob attends the GP clinic regularly to see the nurse and be weighed. The community pharmacy supplies Bob with a *Webster-pak* which they deliver each week. Bob gets a bit breathless sometimes, but manages to attend most of the community and family events.
Establishing a more culturally safe environment in hospitals for Aboriginal and Torres Strait Islander people may need hospital pharmacists to show leadership and advocate for change. The Australian Council for Safety and Quality in Health Care has developed specific standards on how hospitals should engage with consumers and community members as well as a standard for improving medicine safety. For further information, see www.safetyandquality.gov.au.

**Medicine reconciliation and medication management plans**

Accurate and complete medicine history taking can be very difficult. However, there are a variety of resources now available to assist in this process such as NPS Good Medicines Better Health (www.nps.org.au/nps-in-the-community/community-education-sessions/aboriginal-and-torres-strait-islander-communities/good-medicines-better-health-project), the Society of Hospital Pharmacists of Australia (SHPA) Standards of Practice for Clinical Pharmacy Services (www.ssha.org.au/Practice-Standards) and the National Safety and Quality Health Service Standards (www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf).

Medicine information may need to be gathered from a wide range of sources such as outreach clinics, AHSs, medical specialists and community pharmacies. It is important to try to build rapport with the patient before engaging as a health professional. This may be done through some understanding of the patient’s community. Often very sick patients may not be able to engage with pharmacists. Working with an Aboriginal liaison officer or a family member may help.

The National Medication Management Plan (www.safetyandquality.gov.au/our-work/medication-safety/medication-reconciliation/nmmp) provides a standardised process for use by medical, nursing, pharmacy and allied health staff to improve the accuracy of medicines information recorded on admission and provides a useful tool to guide decisions about the appropriate use of medicines for individual patients.

Pharmacists working or providing services in a hospital should develop good working relationships with the local primary care providers (e.g. community pharmacists, AHSs, PHNs and general practices).

**Discharge and transition of care**

Different states and territories and different hospitals have a variety of medicine discharge arrangements with some supplying patients with PBS quantities (usually 1 month supply), some providing a week’s supply of medicines and some providing only enough medicine for 1–2 days. Aboriginal and Torres Strait Islander patients often will not return directly to their home community as they may have follow-up out-patient appointments or they may visit family. Pharmacists involved in the dispensing of medicines at discharge should take into consideration the setting into which the patient is discharged and the availability of follow-up GP and pharmacy services. This will ensure the patient is provided with an adequate supply of medicines, arrangements have been made for appropriate storage (e.g. cold chain for temperature-sensitive medicines) and information regarding the discharge medication action plan is understood by the patient and communicated to the primary care providers.

**Consultant pharmacy**

Evaluations of the Home Medicines Review (HMR) programme suggest that Aboriginal and Torres Strait Islander people could benefit from increased rates of HMRs given the high rates of chronic disease. There is no accurate, accessible data documenting the number of HMRs being undertaken with Aboriginal and Torres Strait Islander patients.

When conducting a HMR for an Aboriginal or Torres Strait Islander patient, pharmacists should consider:

- organising the HMR through the AHS so the patient will be more comfortable and trusting of the process
- seeking the assistance of an AHW during the HMR
- giving the patient a choice of location as some
- Aboriginal and Torres Strait Islander patients do not like strangers in their home and prefer to have their HMR interview at the AHS or in the garden or park
- giving the patient a choice of who attends the HMR interview e.g. a family member or an AHW
- explaining the HMR process
- asking a patient if they would like written material or diagrams
- providing the patient with a follow-up visit or information after the HMR interview.

For further information:

- Prior approval template for HMRs and HMR rural loading allowance forms 5cpa.com.au/programs/medication-management-initiatives/home-medicines-review

When conducting Residential Medication Management Reviews (RMMRs) for Aboriginal or Torres Strait Islander patients in residential aged care facilities, pharmacists may consider:

- having an adequate understanding of the patient’s social and medical history
- identifying the significant family member with whom to discuss medication and health issues
- obtaining a greater understanding of Aboriginal end-of-life beliefs.

For further information:

Scenario 3A: A culturally inappropriate HMR

Pharmacist A received a referral from the local GP to conduct a HMR for Bob, a 75-year-old Aboriginal man, who lives in an Aboriginal community 100 km from town. Pharmacist A rang Bob to arrange an appointment. Bob did not understand why she was ringing; he did not have any recollection of the doctor suggesting a HMR and had no awareness of this programme. He was not very keen for the pharmacist to visit but he eventually agreed after she insisted.

Pharmacist A had some difficulty finding Bob’s house. She was offered a cup of tea by Bob’s daughter but politely refused. She commented on Bob’s nice house and then they sat at the kitchen table and she told Bob about his medicines. She explained that he needed to take exactly what the doctor had ordered. Bob nodded politely as Pharmacist A talked to him about his medicines. There were a lot of people and children coming and going.

After about 40 minutes, Pharmacist A thanked Bob and left. In her report, she explained that she found no major drug interactions but suggested that Bob may benefit from a DAA.

Bob was not sure why the pharmacist had come. He had never met her before. She seemed nice enough, although she looked around the house as if she was surprised it was so nice. She talked a lot about his medicines. She did explain what the medicines were for but it was difficult for him to remember everything because there were lots of kids about. He is still concerned about whether taking all these medicines together is a good idea. He still has little understanding of heart failure and why he has to reduce his salt. He feels tired. He may go and talk to his doctor in a few weeks.

Scenario 3B: A more culturally appropriate HMR

Pharmacist B received a referral from the local AHS to conduct a HMR for Bob, a 75-year-old Aboriginal man, who lives in an Aboriginal community 100 km from town. Pharmacist B liaised with the AHW at the AHS. The AHW organised a visit.

Pharmacist B travelled with the AHW to the community. The AHW explained about Bob’s family and about his history, his fear of doctors and hospitals and his dislike of taking medicines. Bob’s family warmly welcomed the AHW and Pharmacist B and they all sat around the kitchen table and had a cup of tea.

After tea, Pharmacist B asked Bob if he would like to talk about his medicines in the kitchen, or if he would prefer somewhere quieter. They decided that Bob, the AHW, Bob’s daughter and the pharmacist would have their medicines discussion on the back verandah. Pharmacist B asked Bob some questions about how he was feeling about his health and about taking medicines. Pharmacist B showed Bob some diagrams of a heart, explained about heart failure and salt and fluid. She gave his daughter some food suggestions. Pharmacist B explained to Bob why he had a number of different medicines and how they worked. She wrote Bob a medicines list and gave him a booklet on heart failure. She checked Bob had understood the main messages.

After about 60 minutes, Pharmacist B and the AHW farewelled Bob and his daughter. The pharmacist and AHW discussed management of heart failure all the way back to town. Pharmacist B’s report to the doctor suggested follow-up visits from a dietician and exercise physiologist. Pharmacist B also made some suggestions about how Bob’s medication regimen could be simplified.

Bob was very pleased to see the AHW and pharmacist as they helped him to understand heart failure and why he had so many medicines. The pharmacist had reassured him that all the medicines were okay to take together and gave him things to look out for and talk to his doctor or pharmacist about. It was good having the AHW there as he could help explain about heart failure in a simple way. The AHW now also knows about his medicines and said he would come by each week to check how he was going. The booklet about heart failure was a good help, especially for helping his daughter understand what food he could have. Bob was going to make a list of questions for next time he went to the doctor.
6. Aboriginal and Torres Strait Islander pharmacy programmes

Over the last two decades, a number of programmes have been initiated by the Australian Government to improve access to medicines for remote Aboriginal and Torres Strait Islander people.

Rural and urban: CTG PBS Co-payment Measure

- GP assesses patient eligibility and endorses PBS prescription with ‘CTG’
- ACCHS qualifies for QUMAX funding and contracts with pharmacies for services
- Community pharmacy dispenses prescription
- QUM services
- DAAs subsidised
- Medical devices subsidised
- Transport subsidised
- Eligible Aboriginal and Torres Strait Islander patients – subsidised or free PBS medicines

Remote: Section 100 Remote Area Aboriginal Health Services (RAAHS) Programme

- Pharmacy with RAAHS supply contract
- Bulk PBS medicine supply
- Pharmacy with S100 support allowance
- QUM support
- Remote Area Aboriginal Health Service
- Medicines supplied by doctors, nurses or AHWs
- Aboriginal and Torres Strait Islander patient – free PBS medicines

Figure 1. Medicine access schemes for Aboriginal and Torres Strait Islander people
These programmes also assist with the financial burden of chronic disease medicines in urban and rural settings and support AHSs implement quality use of medicine (QuM) initiatives.

The medicine access schemes for Aboriginal and Torres Strait Islander people vary according to geographical location as outlined in Figure 1. Programme-specific rules can make navigation between programmes difficult for both Aboriginal and Torres Strait Islander people and health professionals.

Closing the Gap PBS Co-payment Measure

The Closing the Gap (CTG) PBS Co-payment Measure for rural and urban Aboriginal and Torres Strait Islander people was introduced by the Australian Government on 1 July, 2010 as part of the Indigenous Chronic Disease Package. It was established to reduce the cost of PBS medicines for non-remote Aboriginal or Torres Strait Islander patients living with, or at risk of, chronic disease. The initiative allows patients to access PBS medicines at a reduced co-payment or nil cost.

The patient’s prescription needs to be annotated ‘CTG’ by the prescriber. General (non-concessional) patients presenting a CTG prescription should be charged the current concessional rate for each PBS item on that prescription. Concessional patients presenting a CTG prescription do not need to pay any co-payment for each PBS item on that prescription. However, mandatory charges such as any applicable brand premiums must still be paid. Table 1 illustrates the financial effect of CTG-endorsed prescriptions.

CTG prescriptions can only be written by health professionals who have prescribing rights in an accredited practice and are registered to participate in the Indigenous Health Incentive under the Practice Incentive Programme. These prescribing practitioners may include GPs, medical specialists, nurse practitioners and midwives working at the practice.

Practitioners in an AHS in a rural or urban area, approved by the Minister to participate, may also annotate CTG prescriptions. These prescribing practitioners may include GPs, dentists, optometrists, medical specialists, nurse practitioners and midwives working at the practice.

If the CTG annotation is done manually, prescribers must annotate the prescription with the letters CTG, their initials and signature. When a pharmacist is processing the prescription through dispensing software, he/she must ensure that the CTG code is entered correctly (either manually or automatically). The correct code will depend on the dispensing software. Using an invalid code will result in an incorrect calculation of the patient contribution for their prescription.

Pharmacists may receive prescriptions that are eligible for the CTG PBS Co-payment Measure, but the prescriber may have omitted the CTG annotation. This can cause difficulties for the patient and pharmacist if not handled in a culturally responsive manner (see Scenario 1). Pharmacists are encouraged to establish a protocol with their local GPs or AHSs detailing how to best address the needs of patients in this situation.

Difficulties for patients also occur if they attend a hospital as hospital doctors are not able to participate in the PBS CTG Co-payment Measure. Pharmacists should negotiate with the local AHS or GP as to how they can best manage patient needs and expectations, especially if CTG eligible patients present on weekends or after hours with a prescription without a CTG annotation.

Pharmacists are not responsible for checking the eligibility criteria of a patient for a CTG prescription.

Remuneration for CTG prescriptions is paid with a pharmacy’s regular Medicare prescription claim. No additional documentation is needed. For further information, see CTG PBS Co-payment Measure www.medicareaustralia.gov.au/provider/pbs/pharmacists/closing-the-gap.jsp

Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) programme

The Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People (QUMAX) programme is a QuM support initiative that aims to improve health outcomes for non-remote Aboriginal and Torres Strait Islander people. The focus of the QUMAX programme is to improve QuM through a range of support services provided by participating Aboriginal

<table>
<thead>
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<th>Table 2. Financial effect of CTG-endorsed prescriptions</th>
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<td><strong>GENERAL PATIENT</strong></td>
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<td>Standard PBS prescription</td>
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<tr>
<td>CTG-endorsed prescription</td>
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Community Controlled Health Services (ACCHS) and community pharmacies in rural and urban Australia. The QUMAX programme is jointly managed by The Pharmacy Guild of Australia and NACCHO. The programme commenced in 2008 and funding continued under SCPA.

Only ACCHS registered for QUMAX are eligible to receive QUMAX funding. The ACCHS develop a QUM workplan which outlines the types of support they expect to provide to eligible patients, within an agreed budget before entering into an agreement with a local pharmacy to deliver some or all of the following services:

- DAA support to reduce the cost burden of DAAs from patients
- QUM pharmacist support to fund a pharmacist to assist ACCHS with QUMAX administration, implementation of QUM systems and procedures at the ACCHS
- HMR support to subsidise travel costs, funding for ‘no-shows’ or lengthy consultations
- QUM devices e.g. asthma spacers, blood glucose monitors
- QUM education for AHS staff and patients
- cultural awareness for pharmacy staff
- transport of medicines to patients or patients to the pharmacy.

Pharmacies interested in providing such services to their local ACCHS should contact the ACCHS chief executive officer or practice manager.

For further information:
- NACCHO www.naccho.org.au/promote-health/qumax
- The Pharmacy Guild of Australia QUMAX video www.youtube.com/watch?v=pMCwblQzmqY

Remote Area Aboriginal Health Services (RAAHS) programme – Section 100

Under the provisions of section 100 of the National Health Act 1953, patients of approved RAAHSs can receive PBS medicines without the need for a normal PBS prescription and without paying a co-payment. Most PBS items are available through the RAAHS programme with the exception of:

- schedule 8 medicines
- highly specialised drugs
- extemporaneous products
- doctors’ bag emergency supplies.

Under the RAAHS programme, medicines are ordered by the health services through an approved community pharmacy or hospital pharmacy and these medicines are then supplied ‘in bulk’ to the health services. ‘In bulk’ means medicines are supplied unlabelled and not recorded under individual patient profiles. These medicines are then supplied to patients by an appropriate health professional (e.g. GP, nurse or AHW) as consistent with the law of the relevant State or Territory.

The patient is not charged a co-payment for this supply and the pharmacy is reimbursed directly by Medicare Australia. The pharmacy is paid a handling or supply fee at a lower rate than a dispensing fee in recognition of the bulk supply practice. The RAAHS programme funding does not pay pharmacists for dispensing or provision of DAAs.

RAAHS supply fee per item = approved price to pharmacy of PBS item + mark-up + handling fee

Pharmacies supplying medicines under the RAAHS programme should also consider issues such as medicine handling, labelling and dispensing and the provision of medicine information and advice for patients.

For further information:

S100 Pharmacy Support Allowance

The S100 Pharmacy Support Allowance is paid to contracted section 90 approved pharmacies and approved hospital authorities for the provision of a range of QUM support services to patients in approved RAAHS participating in the section 100 (s100) supply arrangements (see Figure 2).

Eligible pharmacies receive an annual allowance for the delivery of QUM support services. These QUM services are delivered in accordance with a documented work plan, negotiated and agreed between the participating pharmacy and the RAAHS.

QUM visits should occur regularly and engage patients, as well as providing revision of imprest systems and staff training, as funding allows.

S100 support pharmacists who are visiting AHSs should tailor services to meet the needs of the AHS. The S100 support allowance kit describes some examples of services and provides a template to guide the needs assessment required to develop the work plan.
QUM support activities may include:
- assisting patients through medicines education, clinical interventions, medication reviews, health promotion and prevention activities
- education services to AHS clinical and support staff relating to medicines and their management
- assisting AHSs to maintain systems for the supply of medicines to patients that meet quality standards and legislative requirements.

When developing a service for a remote AHS, in conjunction with a needs analysis, consider the following:
- Which healthcare model is used? (e.g. community controlled or government run). Who is responsible for clinical, financial and day-to-day management? Identify with whom to negotiate the work plan, seek feedback on last year’s plan and to plan for next year. It may also be appropriate to meet with clinical staff at a general staff meeting.
- What is the legislation covering supply to remote areas in your state, including the scope and qualifications required of registered nurses (RNs) and AHW/AHPs?
- What procedures are followed in the clinic in regards to supply of both acute and chronic medicines?
- What clinical protocols are followed? e.g. Central Australian Rural Practitioners Association (CARPA), Primary clinical care manual, Kimberley standing orders.
- Is the health service willing to include the pharmacist as a member of the clinical team? Importantly, what is the attitude to and availability of access to patient records? If an electronic system is used, investigate off site access for clinical chart review.
- What is the available transport for normal and urgent supply and for travel for support visits?
- Ask for the cultural protocol for visiting the community. Are permits required? Is there a sign-in system?

For further information:


**Legislation around medicine supply in remote clinics**

The legislation covering the supply and storage of drugs and poisons is different for each state and territory. In most states/territories, registered nurses and AHPs may supply a limited number of Schedule 2, Schedule 3, Schedule 4 and Schedule 8 medicines without referral to a doctor. Each state

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**Figure 2: Overview of interaction between S100 support pharmacist and RAAHS clinic (provided by National Aboriginal Community Controlled Health Organisation)**
has different qualification needs for nurses and AHWs to supply medicines and treat using standard protocols.

The pharmacist is a valuable resource for remote health professionals wanting clarification on their legal rights and responsibilities with respect to supplying drugs. State or Territory Government websites may have information about supply of medicines in remote AHS as well as access to the poisons legislation. For further information, contact State or Territory Departments of Health.

Clinical protocols

Standardised treatment protocols support the legal supply of medicines by RNs and Aboriginal and Torres Strait Islander health practitioners (ATSIHP) in remote AHSs and act as the guidelines for best practice for doctors, RNs, ATSIHP and pharmacists. However, they are not legal documents, despite being written to reflect what the legislation allows. A critical success factor of standard treatment guidelines is that they are supported by health service policy and that all professions use them across the AHS. Standardised treatment guidelines form the basis for the monitoring of drug efficacy and health centre quality assurance processes.

In the Northern Territory, South Australia and Central Western Australia, remote practice is guided largely by the Central Australian Rural Practitioners Association (CARPA) Standard treatment manual. www.remotephcmanuals.com.au

In Queensland, the Primary Clinical Care Manual is used. www.health.qld.gov.au/pccm

In Western Australia, the Remote Area Nursing Emergency Guidelines are used. www.nursing.health.wa.gov.au/docs/reports/Remote_Area_Nursing_Emergency_Guidelines.pdf

The Kimberley Aboriginal Medical Service Council, Standing Orders/Kimberley Chronic Disease Therapeutic Protocols are also used. resources.kamsc.org.au/standing_orders.html

Listings on the PBS for Aboriginal and Torres Strait Islander people

There is a list of PBS medicines specifically to help with the health needs of Aboriginal and Torres Strait Islander people in addition to the main PBS list. The Aboriginal and Torres islander additional list includes mupirocin ointment, nicotine patches, some antifungal topical treatments, thiamine and magnesium supplements, albendazole and ciprofloxacin ear drops. For further information, see www.pbs.gov.au/info/publication/factsheets/shared/pbs-listings-for-aboriginal-and-torres-strait-islander-people

Care co-ordination and supplementary services (CCSS) programme

The CCSS programme was established in 2009–2010 as part of the Commonwealth’s Indigenous Chronic Disease Package (ICDP). The aim of the CCSS programme is to contribute to improved health outcomes for Aboriginal and Torres Strait Islander people with chronic health conditions through better access to coordinated and multidisciplinary care. Funds for the CCSS programme will be managed by PHN. These organisations must work with the Aboriginal and Torres Strait Islander health sector when planning and delivering the programme and ensure that patients of both mainstream GP practices and AHSs/ACCHs have access to care coordination. CCSS funding can only be used for patients with cancer, diabetes, cardiac, renal and/or respiratory disease.

The programme has two components:
• Care coordination is provided by qualified health workers (e.g. specialist nurses, Aboriginal health workers) to ensure that patients are accessing services consistent with their GP care plan.
• A flexible funding pool (supplementary services) is available for use by care coordinators when there is the need to expedite a patient’s access to an urgent and essential allied health or specialist service (including certain approved medical aids) or the necessary transport to access the service, where this is not publicly available.
Scenario 4A: An ineffective remote site visit

Pharmacist L has been working at the local community pharmacy in a rural town for six months. The pharmacy supplies a remote AHS and its outstation with bulk medicines and also has the Section 100 support allowance contract for this AHS. The pharmacy owner asks Pharmacist L to take over the remote site visits. Pharmacist L finds the work plan and needs analysis for the remote AHS which were prepared about nine months ago. It says that the remote AHS requires assistance with stock management, medication management and dispensing systems and medication education.

Pharmacist L phones the remote AHS and tells them that she will be visiting on Wednesday in two weeks.

On the day of the visit, Pharmacist L drives 250 km to the remote AHS. When she arrives she finds that the nurses and AHWs are very busy as an ear, nose and throat specialist is visiting. They are unable to spend any time with Pharmacist L. She does a bit of tidying and sorting in the medicine room, and removes all out-of-date stock. She then drives another 100 km to the AHS outstation where there is another small clinic with a medicine room. When Pharmacist L gets to the outstation, the clinic is closed as there has been a death in the community. Pharmacist L can’t find anyone who has a key to the medicines room so drives back to town. She is a bit annoyed she didn’t get a chance to check the stock at the outstation after driving all that way.

Scenario 4B: A valued remote site visit

Pharmacist M has been working at the local community pharmacy in a rural town for six months. The pharmacy supplies a remote AHS and its outstation with bulk medicines and also has the Section 100 support allowance contract for this AHS. The pharmacy owner asks Pharmacist M to take over the remote site visits. Pharmacist M finds the work plan and needs analysis for the remote AHS which were prepared about nine months ago. It says that the remote AHS requires assistance with stock management, medication management and dispensing systems and medication education.

Pharmacist M phones the AHS, and asks to speak to the CEO. She introduces herself and says she would like to plan a visit. She asks the CEO when would be the most convenient time to come and if she would like her to conduct any training with staff. The CEO says that some staff training would be terrific and that she will discuss it with other staff and get back to her.

The next day Pharmacist M receives a phone call from Nurse N from the AHS. Nurse N suggests that Pharmacist M visit Tuesday fortnight and asks if she could give the staff some training regarding appropriate use of antibiotics. The nurse suggests that the pharmacist also do some medication reviews with some of the patients. She says she and the AHW P will organise some patients to visit Pharmacist M at the clinic. The nurse also suggests that Pharmacist M phone the AHW O at the outstation to organise a visit for the Wednesday. She says she can organise accommodation for Pharmacist M at the medical house.

Pharmacist M talks to Nurse N a number of times over the next fortnight checking that the training room is booked, accommodation is organised, and clinic space is allocated. Pharmacist M also talks to AHW O at the outstation to organise her visit. During the fortnight, Pharmacist M does some research via the internet, and talks to the Land Council, to learn more about the local community. She also sources some training materials and some patient resources she thinks might be helpful.

On the day before her visit, Pharmacist M phones Nurse N to check that all is in order for visit. She also phones AHW O who informs her that as there has been a death in the community she will be unavailable. However, AHW O organises for the medicine room keys to be left at the Land Council office if Pharmacist M still wants to visit.

On the day of the visit Pharmacist M drives 250 km to the remote AHS. She sits and has tea with Nurse N and some of the other staff on her arrival. She meets with AHW P and they analyse stock and discuss dispensing protocols. Pharmacist M conducts training with the six staff over lunch, before seeing four patients for medication reviews in the afternoon. She stays overnight and decides to do further staff training and medication reviews tomorrow rather than drive to the outstation. Getting to know the staff has been so valuable and rewarding. She hopes her boss will agree to her visiting regularly.
The medical aids that can be accessed through the supplementary services funds by care coordinators are:
- dose administration aids (DAAs)
- assistive breathing equipment (including asthma spacers, nebulisers, masks for asthma spacers and nebulisers, continuous positive airways pressure (CPAP) machines, accessories for CPAP machines)
- blood sugar/glucose monitoring equipment
- medical footwear that is prescribed and fitted by a podiatrist.

The above medical aids may only be acquired using supplementary services funding if:
- the medical aid is not available through any other programme
- the need for the medical aid is related to one of the five chronic diseases targeted by the programme (diabetes, cardiovascular, cancer, chronic respiratory and chronic renal)
- provision of the medical aid is part of a primary healthcare service provided by a GP, specialist or allied health provider (e.g. a pharmacist or podiatrist)
- the patient is educated on the use and maintenance of the medical aid.

**Aboriginal and Torres Strait Islander Pharmacy Assistant Traineeship scheme**

The Aboriginal and Torres Strait Islander pharmacy assistant traineeship scheme aims to support the community pharmacy workforce by encouraging the employment of Aboriginal and Torres Strait Islander people in pharmacy assistant roles.

Incentive allowances of $10,000 are available to community pharmacies to employ and train an Aboriginal and/or Torres Strait Islander pharmacy assistant trainee.

Employing Aboriginal pharmacy staff is an important path to connecting with the Aboriginal community.

For further information, see 5cpa.com.au/programs/aboriginal-and-torres-strait-islander-initiatives/aboriginal-torres-strait-islander-pharmacy-scholarship-program

**Aboriginal and Torres Strait Islander Pharmacy Student Scholarship programme**

Aboriginal and Torres Strait Islander students who enrol in university to study pharmacy may be eligible for one of three scholarships of $15,000 per year for four years.

For further information, see 5cpa.com.au/programs/aboriginal-and-torres-strait-islander-initiatives/aboriginal-torres-strait-islander-pharmacy-scholarship-program
7. Background information

Aboriginal and Torres Strait Islander health

An estimated 670,000 Australians were identified as Aboriginal and Torres Strait Islander in the 2011 census, representing 3% of the total Australian population. Seventy-five per cent of Aboriginal and Torres Strait Islander people reside in cities and non-remote areas. There is significant heterogeneity within the population which consists of diverse nations, each with their own language and traditions.

In 2008, the United Nations Human Development Index ranked Australia the third most developed nation in the world with amongst the highest life expectancy attainable. Yet in the same year, Aboriginal and Torres Strait Islander life expectancy was estimated to be up to 17 years less than the broader Australian population. The need for a national effort to address the unnecessary death, grief and suffering experienced by Aboriginal and Torres Strait Islander people was recognised by the Government. The bi-partisan signing of the Closing the Gap Statement of Intent in 2008 committed to closing the health equality gap between Aboriginal and Torres Strait Islander people and non-Indigenous Australians by 2030. The national effort to ‘close the gap’ is an empowerment-based approach to achieving health equality, maximising the existing strengths of Aboriginal and Torres Strait Islander individuals, families and communities.

Aboriginal and Torres Strait Islander people experience a disproportionately high prevalence of morbidity and mortality from chronic illnesses such as diabetes, renal disease and cardiovascular disease. Compared to non-Indigenous Australians, Aboriginal and Torres Strait Islander people are three times more likely to die of cardiovascular disease, 10 times more likely to die of diabetes and 30 times more likely to die from end-stage renal disease. Smoking is responsible for 1-in-5 deaths of Aboriginal and Torres Strait Islander people and is the most preventable cause of poor health and early death.

Aboriginal and Torres Strait Islander people are more likely to suffer asthma, communicable diseases, eye and ear problems and are twice as likely to be hospitalised for mental and behavioural disorders. Tropical and developing-country diseases such as tuberculosis, rheumatic fever, strongyloides, trachoma and hepatitis B and C are also more prevalent in Aboriginal and Torres Strait Islander people than in non-Indigenous Australians.

Aboriginal health services

Aboriginal health services have been established to address the need for more holistic, accessible primary healthcare services for Aboriginal and Torres Strait Islander people.

Despite the higher burden of disease, many Aboriginal and Torres Strait Islander people are less likely to access primary health services. Aboriginal and Torres Strait Islander patients may not access primary health services due to lack of availability, transport and distance to services, cost, language, racism, cultural barriers and family responsibilities.
There may also be a number of psychosocial reasons such as fear of death, fatalism, shame, communication difficulties, lack of Indigenous staff, preference for traditional healers and other spiritual issues which prevent Aboriginal people from accessing health services. Lack of availability of appropriate primary healthcare services can result in increased disease severity and unnecessary hospitalisations. For many Aboriginal and Torres Strait Islander people, hospitals are places to fear. They may have experienced racism and cultural insensitivity in the past and historical events, such as the stolen generation, engender fear of government and government institutions, including hospitals.

Australia’s mainstream medical model often focuses on compliance with medical advice and often ignores the complex historical and sociocultural influences that shape patients’ responses to their health and health care. Many health professionals have a need to ‘fix’ problems and lack awareness of the need to reflect on their own attitudes and approach to build trust and to learn from the community. Building rapport and therapeutic relationships takes time. Health practices need to allow adequate consultation time and implement strategies to manage complex consultations and multi-morbidities, and have follow-up systems in place.

Aboriginal health services deliver targeted services for local Aboriginal and Torres Strait Islander needs. There are two main types of AHS; those that are government operated and those that are community controlled. ACCHS are primary healthcare services initiated and operated by the local Aboriginal and Torres Strait Islander community to deliver holistic, comprehensive and culturally-appropriate health care to the community which controls it through a locally elected board of management. The philosophy of community control and self-determination are reflected in community-initiated, community-driven and community-owned health services. Community empowerment is a vital contributor to health equality.

NACCHO has state affiliates which provide comprehensive lists of ACCHS contacts. Local ACCHS can be found at [www.naccho.org.au/about-us/affiliates](http://www.naccho.org.au/about-us/affiliates)

**Aboriginal health workers (includes Aboriginal and Torres Strait Islander health practitioners)**

AHWs play a vital role in the primary health workforce. They perform a broad range of tasks including:

- taking part in case management and follow-up, either independently or with other healthcare providers
- providing health education to individual patients and health staff
- assisting clients to navigate the health system
- providing cultural education to people outside the cultural community
- providing life skills education, counselling and referral for crisis intervention in the community they serve
- providing input into the planning, development, implementation, monitoring and evaluation of all health programs in the community
- conducting administrative duties including budgeting and correspondence.

AHWs are pivotal members of AHSs as they perform a broad range of clinical and social services while working towards ensuring cultural safety and effective communication between Aboriginal and Torres Strait Islander patients and healthcare professionals. AHWs can assist people navigate the healthcare system and they usually understand community needs and its complexities. Many AHWs play an important role in delivering and administering medicines.

The duties performed by AHWs will depend on their qualifications and the AHS needs. The qualifications of AHWs vary. AHWs who have completed a Certificate III in Aboriginal and Torres Strait Islander Primary Care can then choose a community care or practice stream Certificate IV. In 2012, national accreditation of Aboriginal and Aboriginal and Torres Strait Islander health practitioners occurred for Aboriginal health workers with a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice). AHWs with qualifications in community care are not registered practitioners; however they still play a vital role in the care of Aboriginal and Torres Strait Islander people. Registered AHWs are now titled Aboriginal and Torres Strait Health Practitioners.

Aboriginal health workers may be given other titles such as Aboriginal liaison officers, Aboriginal care co-ordinators, Aboriginal education officers and may work in community health, hospital, PHOs and council settings. AHWs are often the first point of contact for connecting with Aboriginal organisations and Aboriginal patients. Pharmacists are encouraged to establish relationships with their local AHWs.

**Medicines and Aboriginal and Torres Strait Islander people**

Despite having two-to-three times higher levels of illness, underuse of medicines is evident in Australian Aboriginal and Torres Strait Islander populations.

Poor adherence to prescribed medicines is well documented and associated with adverse health
outcomes in all population groups. Social circumstances, deficiencies in health services and systems mean Aboriginal people often suffer even greater challenges in medicine management than non-Indigenous Australians. Barriers to accessing medicines include financial and geographic constraints, failed patient–clinician interactions, poor healthcare delivery systems and complex therapeutic regimens. Other barriers include poverty, educational disadvantage, crowded households, racism, fatalism, the shame involved with sickness and medicine taking, and inadequate health professional support.

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.

Non-adherence to treatment may be a direct reflection of poor standards of health practice, ineffective communication and lack of a shared understanding of health concepts between patients and health professionals. There is often miscommunication between a non-Indigenous health professional and an Aboriginal and/or Torres Strait Islander patient. Miscommunication may be contributed to by language differences and differing belief systems regarding illness.

Patient counselling, clarifying concepts, using educational tools to foster communication, written information, regular communication and follow-up, and family engagement can assist adherence to medicines. Improved medicines management is an important issue requiring sustained attention to enable improvements in the health and welfare of the Australian Indigenous population.

With the introduction by the Australian Government of the RAAHS program in 1999, QUMAX in 2008 and Closing the Gap Pharmaceutical Benefit Scheme (PBS) Co-payment Measure in 2010, some of the financial barriers preventing access to medicines for many Aboriginal and Torres Strait Islander people have been removed. There is little research that assesses whether improved access to medicines has resulted in improved health outcomes. While addressing financial barriers to accessing medicines may assist, it is unlikely to be sufficient to ensure improved health outcomes. In some remote areas, patients have little or no access to community pharmacy and/or pharmacists, and often rural and urban patients also have limited interactions with pharmacists. Complex healthcare systems, poly-pharmacy and inadequate delivery of medicine information may contribute to poor quality use of medicines and medication adherence.

Complex medicine regimens may result in some Aboriginal and Torres Strait Islander patients finding medicines confusing and difficult to manage. More comprehensive verbal and written patient information about medicine indications, mechanisms of action, potential side effects, drug interactions and duration of therapy is needed. Effective communication by the doctor and the pharmacist with patients about medicines is crucial. Miscommunication occurs frequently and health professionals are often unaware of the inadequacy of the interaction. Health professionals need to continually reflect and review their practices. More culturally appropriate, jargon-free written resources or pictorial resources may be required. Greater understanding and empowerment about medicine choices seem to be likely to improve medicine adherence.

Many patients have little understanding of the role of the pharmacist. Pharmacists need to educate patients and health services about their role as ‘medicine experts.’ Pharmacists need to engage with local communities and effectively promote the services they offer and the benefits of these services to individuals, families and communities.

Studies confirm that pharmacist interventions across population groups result in improved patient health outcomes, improved medicine adherence, reduced hospitalisations and reduced healthcare costs. Pharmacists need to partner with patients to establish realistic therapeutic goals and negotiate medicine adherence targets in order to improve Aboriginal and Torres Strait Islander peoples’ health outcomes.

NPS, partnering with NACCHO, has established the Good Medicines Better Health project. This project was designed to assist AHWs improve their knowledge and skills about medicines, based on the principals of QUM. Pharmacists can play an important role in assisting AHWs with their medicine knowledge. NPS also develops training resources for AHWs and provides education to pharmacists working with Aboriginal and Torres Strait Islander patients. For further information, see www.nps.org.au/nps-in-the-community/community-education-sessions/aboriginal-and-torres-strait-islander-communities/good-medicines-better-health-project

There are a number of programs through which Aboriginal and Torres Strait Islander patients can access medicines. Each of these programs has a different set of eligibility and prescribing criteria. Pharmacists can play an important role in assisting Aboriginal and Torres Strait Islander patients and their prescribing clinicians navigate the program requirements (see Section 6: Aboriginal and Torres Strait Islander Pharmacy programmes).
8. Resources

National Aboriginal organisations

Indigenous Allied Health Australia (IAHA) – national peak body representing Aboriginal and Torres Strait Islander allied health professionals and students.
68 Thesiger Court, Deakin West, ACT 2600
02 6285 1010
iaha.com.au

National Aboriginal and Torres Strait Islander Health Worker Association (NATSIHWA) – professional association for Aboriginal and Torres Strait Islander health workers in Australia.
31–37 Townshend Street Phillip ACT 2606
02 6221 9220
www.natsihwa.org.au

National Aboriginal Community Controlled Health Organisation (NACCHO) – national peak body representing over 150 ACCHS across the country on Aboriginal health and wellbeing issues.
3 Garema Place Canberra City ACT 2601
02 6246 9300
www.naccho.org.au

NSW Aboriginal Land Councils
02 9689 4444

NT Land councils
australia.gov.au/people/indigenous-peoples/land-councils

Consumer resources

Asthma Foundation
General resources including fact sheets and video clips: www.asthmaaustralia.org.au/resources.aspx
Aboriginal and Torres Strait Islander specific resources: Short wind action plan: www.asthmaaustralia.org.au/uploadedFiles/Content/About_Asthma/Resources/AAP_ShortWind.pdf

Australian Indigenous HealthInfoNet
Searchable database of literature about Aboriginal and Torres Strait Islander health: www.healthinfonet.ecu.edu.au/key-resources/promotion-resources

Diabetes Australia
General resources: www.diabetesaustralia.com.au/Resources/Brochures---Booklets1
Aboriginal and Torres Strait Islander specific resource: Healthy Living NT Keeping culture, life family strong – Know early about diabetes www.healthylivingnt.org.au/content/?id=84

Heart Foundation
Useful for Aboriginal and Torres Strait Islander patients: heartfoundationshop.com/shop/?top=0&cat1=%25%25&cat2=Health+Resources&find=&head=Heart%20Foundation%20Shop&find3=&cat3=%25

Aboriginal and Torres Strait Islander specific resources:
• Living everyday with my heart failure www.heartfoundation.org.au/SiteCollectionDocuments/Living-every-day-with-my-heart-failure.pdf
• Warning signs of a heart attack (urban) [heartfoundationshop.com/shop/product/?id=291](http://heartfoundationshop.com/shop/product/?id=291)
• Warning signs of a heart attack (remote) [heartfoundationshop.com/shop/product/?id=288](http://heartfoundationshop.com/shop/product/?id=288)

**Kidney Health Australia**

**Northern Territory Government health education resource directory**

**The Medicines Book for Aboriginal and Torres Strait Islander health practitioners and health workers**
The Medicines Book has been designed for AHWs and others involved in the supply and monitoring of medicines in the remote primary healthcare setting. [remotephcmanuals.com.au/html/publications](http://remotephcmanuals.com.au/html/publications)

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**Aboriginal health information**


Australian Indigenous HealthInfoNet: facts and research about Aboriginal health [www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au)


YouTube: resources for sharing Aboriginal health and wellbeing programs
- Men’s health program – Katherine, NT [www.youtube.com/watch?feature=player_embedded&v=wgEgsShhI_I](http://www.youtube.com/watch?feature=player_embedded&v=wgEgsShhI_I)
- What’s it like being a male Aboriginal health worker [www.youtube.com/embed/wHri_7j9pUA?rel=0](http://www.youtube.com/embed/wHri_7j9pUA?rel=0)
- Closing the Gap: video for Melbourne health staff (video about barriers for patients in hospital) [www.youtube.com/watch?feature=player_detailpage&v=Rdyfl6REmN4](http://www.youtube.com/watch?feature=player_detailpage&v=Rdyfl6REmN4)
Aboriginal culture

There are several online programs which will assist in giving a background of Aboriginal history and culture. These programs could be used during an orientation session. Cultural awareness needs to be learnt from engaging face-to-face with Aboriginal people in the local area.

For further information:
- Learn about culture – Generation One, Reconciliation Australia shareourpride.reconciliation.org.au
- Royal Australian College of General Practice: Cultural awareness and cultural training – online training program for health professionals www.racgp.org.au/yourracgp/faculties/aboriginal/education/cultural-awareness/
- Combined University Centre for Rural Health: Aboriginal cultural orientation for health professionals lms.cucrh.uwa.edu.au/login
- Aboriginal identity www.creativespirits.info/aboriginalculture/people/aboriginal-identity-who-is-aboriginal

Clinical prescribing protocols

Northern Territory, South Australia and Central Western Australia:

Queensland:

Western Australia:
- KAMSC Standing orders/Kimberley Chronic Disease Therapeutic Protocols resources.kamsc.org.au/standing_orders.html

Help lines
- Medicines Line (expert medicines information for consumers) 1300 MEDICINE (1300 633 424) Monday to Friday 9am–5pm AEST www.nps.org.au/contact-us/medicines-line
- Adverse Medicine Events Line (consumers can report a medication problem or side effect) 1300 134 237 Monday to Friday 9am–5pm AEST www.nps.org.au/contact-us/adverse-medicines-events
- Pharmacists’ Support Service 1300 244 910; 8am–11pm 365 days a year www.supportforpharmacists.org.au
References


18. The health and welfare of Australia’s Aboriginal and Torres Strait Islander peoples. 2010. At: www.abs.gov.au/ausstats/abs@.nsf/mf/4700.0


37. Swain L, Barclay L. They’ve given me that many tablets, I’m bushed. I don’t know where I’m going. Aust J Rural Health 2006;14:Apr-Jun


## Appendix 1

<table>
<thead>
<tr>
<th>COMMUNITY CULTURAL ORIENTATION CHECKLIST</th>
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<tbody>
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<td>Pharmacist name</td>
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<td>Death and dying</td>
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<td>Sad news, sorry business</td>
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## Appendix 2

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