

Submission

Green Paper: Delivering Safe and Sustainable Clinical Services

February
2015

Purpose

The PSA makes this submission to the Department of Health and Human Services Green Paper: Delivering Safe and Sustainable Clinical Services. This submission will focus on the role that pharmacists can play in ensuring safe and sustainable clinical services

This submission is drawn substantially from recent submissions prepared in other jurisdictions including PSA Nationals 2015-2016 budget submission and PSA Victorian Branch Submission to the Victorian state governments Inquiry on the role and opportunities for community pharmacy in primary and preventative care in Victoria. We thank and acknowledge the permission of the PSA as authors of those papers for their use.

About PSA

PSA is the peak national professional pharmacy organisation representing Australia's pharmacists working in all sectors and locations. PSA's core functions include: providing high quality continuing professional development, education and practice support to pharmacists; developing and advocating standards and guidelines to inform and enhance pharmacists' practice; and representing pharmacists' role as frontline health professionals. Over 60% of pharmacists in Tasmania are members of the PSA, with nearly 15,000 members nationally.

Safe and Sustainable Clinical Services

The PSA wholeheartedly endorses the need for fundamental change to how service delivery occurs in Tasmania. For too long we have seen inferior outcomes for higher cost, this must change and we believe that pharmacists especially in the interface between primary care and tertiary care should be part of the solution.

Below we provide a direct response to a number of the community consultation questions posed by the Green Paper and provide some additional ideas and input on how pharmacy can assist in addressing question one "Is the Tasmanian health system all it should be, or should we be open to change in order to improve outcomes for all Tasmanians regardless of where they live?"

Clinical Consultation Questions One - Four

- *How well does the proposed framework align with practice in your discipline?*
- *Where are the areas of service duplication in your discipline?*

- *Where are the gaps?*
- *Are there any services being inappropriately provided, or planned, at your facility?*

With regard to the role definition matrix and the role delineation framework PSA believe both reasonably capture the range of roles for pharmacy. However the matrix and the role delineation framework both underestimate the importance of medication management in health care. It is currently estimated that 230,000 admissions to hospital are medication related at a cost of approximately \$1.2 billion annually¹. Pharmacists have roles in reducing risk of medication misadventure at all levels, and while patient acuity may vary at each episode of care the complexity of the medication regime is often unrelated and more complex than the acuity level will indicate. As such level 1, and to some extent level 2 underestimates the role of the pharmacist in providing clinical medication monitoring and support services and has too much focus on their supply role. Nor does it adequately address the shared responsibility of care between community pharmacy and Hospital Pharmacy Departments with respect to S100 medication, chemotherapeutics, Opioids and Opioid substitution programs and other medication where there is a mix of access and supply due to the complexity of the PBS, state based service or hospital formulary. Improving the communication between the hospital sector and community pharmacy is key to reducing medication error and wastage at the supply level.

There is insufficient emphasis on the need for assessment of medication monitoring, clinical review, medication reconciliation, transfer of care between the tertiary and community sector, especially where both are sharing responsibility for consumers in receiving level one service. As an example current discharge summaries may only include partial medication patients on discharge. These lists of medication often include medicine dispensed by the pharmacy departments in the major hospitals at discharge, but do not include medications returned to patients from their own supply for ongoing use. As such incomplete medication lists can result in treatment failure and patients being re-admitted. Improved communication and access to accurate shared records would contribute to improving this. Home Medicine Reviews on discharge for patients identified at risk may also assist in alleviating this problem. This vital service was to be initiated during the 5th Community Pharmacy Agreement however has yet to begin.

PSA strongly believes that level 1 and level 2 need to include reference to the role of the pharmacist as a provider of patient education and support, including through the provision of in pharmacy medication support (Medchecks) Home and Aged Care Medication Reviews in collaboration with the patients usual General Practitioner. In addition the pharmacist would need to provide other clinical services including drug information, drug monitoring, drug utilisation evaluation, adverse drug reaction reporting, and membership on relevant community, aged care and hospital network committees (e.g. Medication Advisory Committees, and Clinical Governance Committees). This role may be a shared role between both community pharmacist, hospital based pharmacists, other drug service pharmacists etc.

¹ Australian Commission on Safety and Quality in Health Care (2013), *Literature Review: Medication Safety in Australia*. ACSQHC, Sydney.
URL: <http://www.safetyandquality.gov.au/wp-content/uploads/2014/02/Literature-Review-Medication-Safety-in-Australia-2013.pdf>

Level 1 and 2 also underestimate additional roles and functions that pharmacists undertake at all facets of the health care system as such level 1 and 2 also require:

- Timely access to clinical information, including medical records, medication history and pathology results
- May provide pharmacy undergraduate and postgraduate teaching role
- Appropriate networking with higher level service
- Must comply with Poisons Act 1971 and Pharmacy Board of Australia legislation regarding storage and security requirements

It is important to remember that medication reconciliation and review need to occur along the continuum of care, regardless of acuity. And that at lower levels of acuity the volume of people needing the service will be greater, and as such will require adequate resourcing.

Clinical Consultation Question Two

- *How do we promote and maintain safe primary and community care to consumers and communities such that they seek out these services rather than attend Emergency Departments when their conditions are more advanced?*
- *How do we determine which services to focus on to expand the role of primary and community care?*

PSA believes promotion of community pharmacies as triage destinations would have the potential to reduce the strain on both general practice and EDs. Pharmacists have sufficient training in red flags for referral and can adequately triage many conditions which walk through the door. It may be possible to develop Tasmanian approved triage protocols for pharmacists to follow using existing minor ailment frameworks, referral to afterhours GP Assist phone support to increase the confidence level for pharmacists that they are appropriately advising, rather than resorting to a tendency to refer to ED especially out of hours 'just to be safe'.

Endorsement and promotion of the HealthPathways project by Tasmania Medicare Local would ensure all health care professionals are on the same page and know when and where to refer patients, and what treatment options available across the continuum of care.

An increased focus and innovative support to increase the pharmacy services available in the after hours space and on promoting pharmacies as places to go for minor ailments and for initial advice/triaging to minimise ED presentations is advised. Also increasing the role of

the after hours GPs and the inclusion pharmacist and pharmacies as a site for telehealth consultations should be encouraged.

Continuing to address the pathways of communication between community pharmacists and either GP assist or ED physicians to enable the community pharmacist to ask for a second opinion in cases where they aren't sure whether referral is indicated or where best to refer a person in need. Additional placement and inclusion of pharmacists in ED triage roles may also reduce load on EDs².

PSA believes that there are a range of pharmacy related clinic services - e.g. anticoagulation clinics, palliative care support, chronic disease self-management support could be delivered through community pharmacy in a collaboration with General Practice and tertiary services. Existing examples in Tasmania include diabetes medchecks for routine support of non-complex patients, wound care clinics, outreach support from cancer services.

PSA also believes a collaborative approach to provision of outpatient pharmaceuticals (for those under the Pharmaceutical Benefits Scheme) via community pharmacies - would be cost effective, convenient for consumers by reducing travel and waiting times for consumers. It would also reduce pressure on the clinical pharmacy departments and improve the holistic nature medication record in the community

Below are additional examples of how PSA believes pharmacy and pharmacists can have a role in improving the state of the healthcare system within Tasmania.

Quality use of medicines (QUM) policy

Pharmacy practice in Australia is firmly underpinned by Australia's policy on Quality Use of Medicines (QUM).³ Briefly, the elements of the policy are to:

- a. Select management options wisely by: considering the place of medicines in treating illness and maintaining health; and recognising that non-drug therapies may be the best option for the management of many disorders.
- b. Choose suitable medicines, if a medicine is considered necessary, so that the best available option is selected by taking into account: the individual; the clinical condition; risks and benefits; dosage and length of treatment; any co-existing conditions; other therapies; monitoring considerations; and costs for the individual, the community and the health system as a whole.
- c. Use medicines safely and effectively to achieve the best possible results by: monitoring outcomes; minimising misuse, over-use and under-use; and improving

² <http://www.dailymail.co.uk/news/article-2942099/Private-pharmacists-brought-treat-E-patients-Trial-service-free-equivalent-two-doctors-nurses-shift.html>

³ Australian Government Department of Health and Ageing. The national strategy for quality use of medicines: Executive summary. Canberra: Commonwealth of Australia, 2002.

people's ability to solve problems related to medication, such as adverse effects or managing multiple medicines.

In the context of this policy, the role of pharmacists relates not only to medicines use and management but also in providing advice on non-drug management where appropriate, providing support and information, and working across the whole spectrum of health from maintenance of good health to management of ill health.

Medicine use is increasing and so are adverse drug events

The growing burden of chronic disease is seeing a commensurate increase in medicines use. Over 80% of Australians aged 65 years and over, and about 70% of Australians aged 45-64 regularly use pharmaceuticals, with these proportions expected to further increase. Medicines are the most common treatment used in health care and contribute to significant improvements in health when used appropriately. Australia spends over \$16 billion each year on medicines or around \$700 for every man, woman and child in Australia – every year. By comparison, we don't spend very much on medication safety and we don't pay anywhere near enough attention to reducing the occurrence and severity of medication errors.

All medicines have the potential for side effects and can interact with other medicines. Each year 230,000 people are admitted to hospital, and many more people experience reduced quality of life, as a result of side effects of their medicines. This comes at a cost to the system of more than \$1.2 billion. The COAG Reform Council's recent report documented increases in potentially preventable hospital admissions. Much of this personal and financial burden is preventable, with increasing evidence of the impact that pharmacists can have on medication safety and adherence, and the resulting savings to the health system.

Accessibility to trained health professionals

Pharmacists are one of the most accessible and trusted health professionals.⁴ While their primary expertise revolves around medication management issues, pharmacists also have training and good grounding in broader health and scientific issues. Pharmacists are ideally placed to offer healthy lifestyle advice to consumers, not only when dispensing their prescriptions but when dealing with requests for non-prescription products or treatment of minor ailments.

The most recent figures⁵ available indicate there are 27,560 pharmacists in Australia. The gender ratio is 6:4 (female to male). Unlike professions such as medicine or nursing which have a generally even distribution of age of practitioners, the pharmacy profession is moderately skewed towards a higher proportion of practitioners in the younger age groups.

4 Roy Morgan. Images of professions [survey]. 8 April 2008.

5 Pharmacy Board of Australia. Pharmacy registrant data: December 2013. 2014; Jan. At: www.pharmacyboard.gov.au/documents/default.aspx?record=WD14%2f13040&dbid=AP&checksum=HXwmz%2fcrCwQqSZvZzP%2bOkA%3d%3d

In Australia there is a well-established network of community pharmacies to support equitable access for Australians to medicines, health information and professional advice, in most cases without the need to make an appointment. It has been quoted that every person in Australia visits a pharmacy on average 14 times a year. This equates to several hundred million intervention opportunities per year. At these visits, pharmacists and their staff regularly perform brief interventions which can involve general health advice but also more in-depth discussions on preventative health topics.⁶

The contribution of pharmacists is not confined to one health sector or one population group. Pharmacists participate in the acute care sector and in the community, for the management of chronic conditions and treatment of minor ailments, and provide care for young and old.

The role of pharmacists is extremely diverse as they are involved in population level education and awareness campaigns as well as targeted or tailored interventions for individuals. Pharmacists engage and interact with consumers about a wide spectrum of health care needs ranging from prevention, early detection and screening stages through to treatment and palliation.

In Tasmania the wide geographic distribution of the 154 community pharmacies⁷ means most Tasmanians have access to a local pharmacist often over extended trading hours. Combine this with the two private hospital pharmacies and four public hospital pharmacy departments and the Tasmanian community has good access to an extensively trained network of over 670 pharmacists.

Collaborative partnerships

Pharmacists' skills in QUM can provide benefits and synergies in a collaborative team environment. This is observed where pharmacists have strong professional partnerships and active engagement with other health professionals. The partnership approach also supports pharmacists liaising closely with general practitioners and referring in a timely and sensitive manner.

Pharmacists currently work in partnership with other health professionals in various settings including hospital wards or clinics, residential aged care facilities and in the community. This is most clearly established in the tertiary sector where the pharmacist is an integral part of the team from surgical pre-admission clinics to Intensive Care Units.

Community pharmacists have equally strong professional links with other health practitioners within the local primary health care team. In particular, collaborative partnerships between community pharmacists and local general practitioners are fundamental to the provision of timely and seamless primary health care. From maintaining medication supply to comprehensive medication reviews pharmacists are a key component of the health sector in the primary care setting. The role of pharmacists relates not only to medicines use and management but also in

⁶ See for example: www.pharmacyhealthlink.org.uk

⁷ Tasmanian Pharmacy Authority complete list of registered pharmacies
<http://www.pharmacyauthority.tas.gov.au/uploads/Practice%20Address.pdf>

providing advice on non-drug management where appropriate, providing support and information, and working across the whole spectrum of health from maintenance of good health to management of ill health.

Some pharmacists have also been working in general practices with great success. This arrangement creates additional benefits in that pharmacists can provide information and education on medicines and medication management to prescribers and practice nurses.

However, formal recognition and funding of the contribution of pharmacists to such team arrangements are sadly lacking in Australia. Hence, PSA has been advocating for formal recognition of collaborative arrangements where we believe pharmacists' expertise would be used most effectively and could help create synergies in health care service delivery to the consumer. PSA's support for better integration of pharmacists in the health care team has been strongly advocated through many different practice areas but particularly in relation to mental health care.

Pharmacist Training

Approximately 35-55 pharmacy students graduate from the University of Tasmania. Pharmacy education is a four year degree program with an additional full time internship year of 1824 hours supervised practice before candidates are allowed to sit for the Pharmacy Board of Australia registration examinations. Besides having a focus on drug actions, pharmacists are highly educated across a broad spectrum of disease states and organ systems, as well as health promotion and disease prevention. Over 12% of community pharmacists have post graduate qualifications.⁸

In addition to formal postgraduate qualifications, many pharmacists acquire further training and skills upgrades in a broad range of practice areas including Opioid Replacement Therapy, Wound Management, Compounding, Medication Management Review, Diabetes Management, Asthma Management, Sleep Apnoea Management, Motivational Interviewing, and others.

There is a mandatory registration requirement by the Pharmacy Board of Australia to undertake continuing professional development of 40 CPD Credits per year. Over 30% of Pharmaceutical Society of Australia (PSA) members exceed this mandatory requirement and engage in substantial amount of professional development on an ongoing basis.

Pharmacists are highly qualified health professionals yet their skills, knowledge and expertise are often under-recognised and under-utilised, as highlighted in the recent Grattan Institute Report.⁹

Where pharmacists work / patient centred home model

⁸ APESMA, Community & Hospital Pharmacists' Remuneration Survey Report 2012.

⁹ Duckett, S., Breadon, P. and Ginnivan, L., 2013, Access all areas: new solution for GP shortages in rural Australia, Grattan Institute, Melbourne

Latest reports indicate 63% of pharmacists work in community pharmacy but the actual figure of community pharmacists in practice may be as high as 80%¹⁰. This is due to the report only showing the primary place of practice and there are many pharmacists working part time in community pharmacies in addition to their primary job. Another 8.5% of pharmacists practise in other settings in the community such as community health centres, medical clinics, aged care facilities and in consumers' homes (providing medication reviews).¹¹

The breadth of locations in which pharmacists work is supportive of the proposed shift towards a model of care known as the Patient-Centred Medical Home (PCMH). The PCMH has been proposed as a model for transforming primary health care and improving the efficiency and effectiveness of the health system, particularly for consumers with chronic disease. The principal feature of this model is the identification of a health care professional who leads a team which takes responsibility for all the health care needs of an individual and coordinates care with other health professionals. Payment systems reward the added value provided by the medical home.

In Australia, much of the literature around the medical home has been focussed on transforming General Practices into a medical home, and envisaging only a very limited, peripheral role for providers such as pharmacists¹². This is in contrast to international models, including the widely-cited Seattle Group Health Cooperative¹³ and it means that Australia is again lagging behind in terms of applying evidence-based models. The models in which significant benefits have been demonstrated employ care teams that are indeed led by GPs, but use an expanded staffing model in which nurses, clinical pharmacists and others assume greater care management roles.¹⁴

Roles that pharmacists can fulfil as part of a PCMH team extend well beyond the walls of a community pharmacy, and can include but are not limited to the following¹⁵

- Identifying, resolving, preventing, and monitoring medication use and safety problems;
- Reducing poly-pharmacy and optimising medication regimens on the basis of evidence- based guidelines;
- Recommending cost-effective therapies;
- Designing tailored adherence and health literacy programs;

¹⁰ ABS, Census of population and housing 1996-2011.

¹¹ HWA, Australia 'Health Workforce Series: Pharmacists in focus, March 2014

¹² See <http://medicalhome.org.au/>

¹³ Reid RJ et al. The Group Health Medical Home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. Health Affairs, May 2010; 835-843

¹⁴ Reid RJ et al. The Group Health Medical Home at year two: Cost savings, higher patient satisfaction, and less burnout for providers. Health Affairs, May 2010; 835-843

¹⁵ Smith MA and Nigro SC. The Patient-Centred Medical Home. Science and Practice of Pharmacotherapy. PSAP-VII; 87-102

- Developing consumer medication action plans with self-management goals; and
- Communicating medication care plans to consumers, cares and other health care professionals in the team.

(See image on following page)

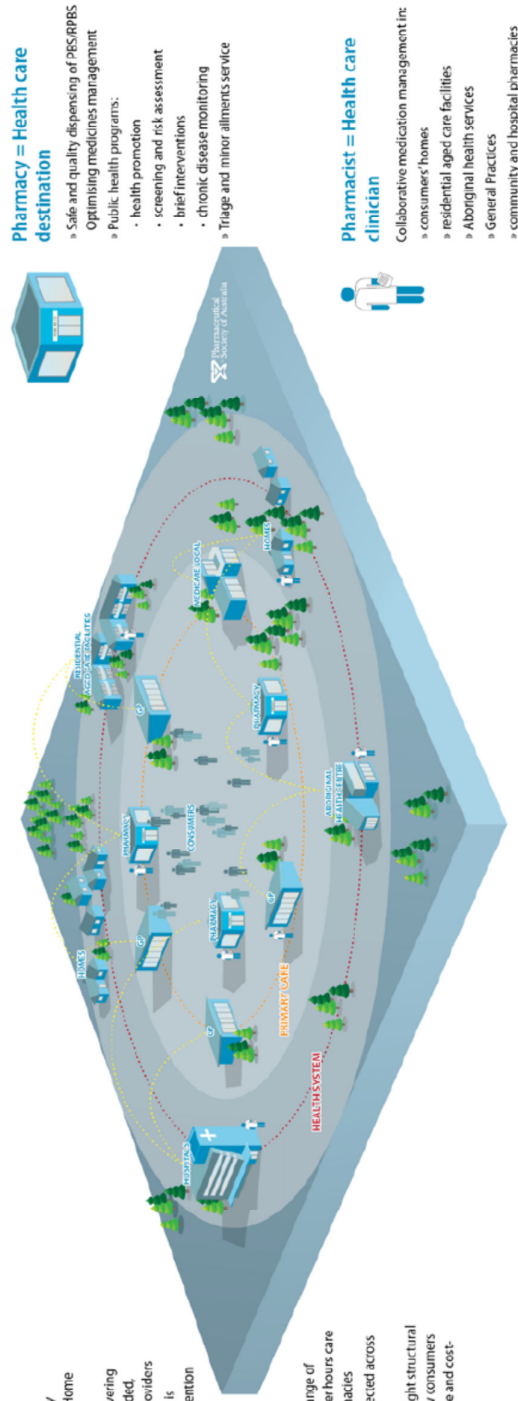
Pharmacists and the patient-centred medical home

Key features

PSA's proposals seek to align with the key features of the Patient-Centred Medical Home model, in that they are:

- Patient-centred – pharmacists are delivering services where and when they are needed, and in collaboration with other care providers
- Comprehensive – the focus of services is across the spectrum of care, from prevention to chronic disease care
- Coordinated – the contribution of the pharmacist is part of the broader health care system, with effective documentation and communication
- Accessible – having pharmacists in a range of settings increases accessibility, and after hours care is available at many community pharmacies
- Committed to quality and safety – reflected across all of the proposed programs

Underpinning this approach is that the 'right structural and funding systems are in place to allow consumers to move to the most clinically appropriate and cost-effective setting.



Reducing emergency department presentations for minor ailments

Minor ailments are defined as conditions that are often *self-limiting, with symptoms easily recognised and described by the patient and falling within the scope of pharmacist's knowledge and training to treat*. These conditions can usually be managed with the use of non-prescription products available to a pharmacist and through self-care.¹⁶

As part of their contribution to primary health care, pharmacists and pharmacies play an important role in the treatment and management of minor ailments and illnesses. Pharmacists are one of the most easily accessible healthcare professionals, and in a recent study, 51% of consumers said they would consult a pharmacist/pharmacy staff about minor ailments in the first instance for advice.¹⁷

Minor ailment schemes operated through pharmacies have the potential to redirect care of minor ailments away from general practice and other high cost settings such as emergency departments as intended¹⁸

The following section outlines some examples of existing initiatives and projects that are making better use of pharmacists in dealing with minor ailments and reducing emergency department presentations.

Existing initiatives

International minor ailment schemes

The *Pharmacy First* minor ailments scheme operated by Nottingham NHS for over a decade has been accessed by more than 250,000 consumers who would otherwise have added to the pressure on GP resources.¹⁹ Similar schemes operate in other parts of Britain, Scotland, and Canada.

In England the schemes are authorised by the NHS and commissioned by the Clinical Commissioning Groups, depending on local need.²⁰ Pharmacies are reimbursed the costs of the

¹⁶ Pharmaceutical Society of Australia. *A framework for pharmacy-delivered minor ailments services [draft]*; 2013: Canberra

¹⁷ Price Waterhouse Coopers. *Consumer Needs*; 2013 [in progress] Project RFT2010/11-01 funded by the Australian Government through the 5th Community Pharmacy Agreement Research and Development Program

¹⁸ Paudyal V et al, 2012. *Health and cost-related outcomes of community pharmacy-based minor ailment schemes: a systematic review* [Report]

¹⁹ Puntong S, Boardman HF, and Andersen CW. *A multi-method evaluation of the Pharmacy First Minor Ailments scheme*. International journal of clinical pharmacy 06/2011; 33(3):573-81

²⁰ National Health Service. *Community pharmacy minor ailment schemes*. 2004; United Kingdom

medicines, but the methods by which the consultation costs are paid vary among schemes, and include²¹

- a fee per consultation
- banded fee structures, based on no. consultations
- annual or one-off retainer

In New Zealand Medsafe²² has approved the rescheduling of trimethoprim to treat urinary tract infections. It may now be supplied by a pharmacist, who has undergone an approved training program. Nurse practitioners in some jurisdictions in Australia are also able to prescribe trimethoprim under protocols. Rescheduling with appropriate controls and training requirements should be considered in Tasmania.

ACT Medicare Local (ACTML) After Hours initiative

ACTML now supports 5 pharmacies along with 14 general practices to enhance access to after hours care. ACTML and the Pharmaceutical Society of Australia (PSA) have worked together to deliver an educational program to directly educate pharmacists and their staff, and indirectly educate the ACT community with the aim of meeting the following key objectives:

- Improving knowledge and awareness of pharmacists and their staff relating to availability, and appropriate use, of services in the ACT.
- Improving knowledge and skills of pharmacists and their staff with regard to triage, management and referral of common after hours presentations.
- Increasing awareness amongst the local community of availability, and appropriate use, of afterhours primary care services via pharmacists and their staff.
- Improving usage of relevant and appropriate services by the community

The project was found to be successful and an extension project is being planned.

Opportunities in Tasmania

There is great potential for Tasmania to adopt the concepts outlined above. While pharmacists are already the first point of call for the public to diagnose and treat a range of minor ailments,

²¹ Baqir W, Learoyd T, et al. *Cost analysis of a community pharmacy 'minor ailment scheme' across three primary care trusts in the North East of England*. J Pub Health; 2011

²² <http://www.psnz.org.nz/public/cop/documents/UTIAAlgorithm.pdf>

they have to refer the consumer to their GP for further consultation due to their needs for Schedule four (S4) medicines. In remote areas, where GP access can present a challenge, consideration could be given to allowing pharmacists limited prescribing rights equivalent to that of nurse practitioners. Many minor ailments such as wound care, minor infections and skin conditions, common cough and cold, allergies may be provided by pharmacists, easing the burden on the workload of GPs and emergency department presentations.

PSA recommends the following potential projects for consideration in Tasmania:

- A pilot of a minor ailment scheme in selected locations where GP supplies are inadequate and pharmacists may be selected, trained and supported to take care of less complex health conditions.
- A pilot of a similar program to the ACTML initiative, with potential extension to all hours, as primary-care type presentations to emergency departments are actually more common during normal hours than after hours.²³ By doing so it is likely that consumers may receive advice from pharmacists through a triage exercise and be referred to appropriate health professionals or services. This would save time, enhance timely and appropriate treatment, and potentially reduce unnecessary burden on hospital emergency departments.

Reducing hospital readmissions

Most Australians will at some stage of their lives need to take prescription and other medicines, and by the time they are 65, many people will be regularly taking 5 or more medicines. For those with a chronic disease or mental illness, the number can be even higher.

In 2010 an estimated 271 million prescriptions were dispensed²⁴ and millions more medicines prescribed by pharmacists for minor ailments and conditions. Pharmacists play a key role in ensuring that all Australians have ready access to supplies of their essential medicines, especially those 7 million people with chronic disease.

Recognising the impact that medicines have on the health and safety of Australians, medication safety is a high priority for national health organisations including the Australian Commission on Safety and Quality in Health Care, the Australian Council on Healthcare Standards and the National Prescribing Service. Each of these organisations outline goals, set standards or deliver programs for achieving better medication safety for all Australians.

All medicines have the potential for side effects and can interact with other medicines. Each year 230,000 people are admitted to hospital and many more people experience reduced quality of life as a result of side effects of their medicines. This comes at a cost to the system of more than \$1.2

²³ Gafforini S and Carson N, 2013. *Primary-care type presentations to public hospitals: A local in-hours and after-hours population comparison*. Final Report

²⁴ Australian Institute of Health and Welfare. *Australia's health 2012*. Canberra. AIHW, 2012: 404.

billion.²⁵ The COAG Reform Council's recent report documented increases in potentially preventable hospital admissions.²⁶ Significantly, Medication-related admissions account for 20-30% of all hospital admissions for people over 65.²⁷ Much of this personal and financial burden is preventable.

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

The following section outlines some examples of existing initiatives and projects that are making better use of pharmacists in improving medication use for consumers with chronic diseases.

Existing initiatives

Hospital-initiated Home Medicines Review (HMR)

This initiative is pending implementation as part of the 5CPA. It recognises the benefit a HMR service may offer to patients who are at high-risk of medication misadventure in the immediate post-discharge period, where they do not have access, or timely access, to a GP.²⁸ It appears unlikely to be implemented before the completion of the 5CPA in June 2015.

US initiative

University of Cincinnati's College of Pharmacy has recently announced a study which will pair 1,000 patients who are at high risk for readmission with a community pharmacist. It will focus on patients with complex disease states: heart failure, COPD, pneumonia, MI or diabetes. Based on the pilot, the researchers are estimating a 20% reduction in readmissions if high-risk patients receive counselling and medication management by a community pharmacist.²⁹

²⁵ Australian Commission on Safety and Quality in Health Care, 2013. *Literature Review: Medication Safety in Australia*. ACSQHC, Sydney

²⁶ COAG Reform Council 2014, *Healthcare in Australia 2012–13: Five years of performance*, COAG Reform Council, Sydney

²⁷ Roughead EE, Semple SJ. *Medication safety in acute care in Australia: Where are we now?* Part 1: A review of the extent and causes of medication problems 2002-2008. Australia and New Zealand Health Policy 2009;6(1)

²⁸

[http://www.health.gov.au/internet/main/publishing.nsf/Content/C564BCC09573D8D1CA257BF0001BAF31/\\$File/Consultation%20paper%20FINAL%20for%20consultation%20December%202011.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/C564BCC09573D8D1CA257BF0001BAF31/$File/Consultation%20paper%20FINAL%20for%20consultation%20December%202011.pdf)

²⁹ Insurance News, Pharmacy Study Expects to Lower Hospital Readmissions, 22 Jun 2014 www.insurancenewsnet.com

Opportunities for Tasmania

Research shows that deficiencies in communication are the most common contributing factor to the occurrence of medication errors, including shortcomings in communication between GPs and pharmacists. It is possible that over time, e-health initiatives such as the Personally Controlled Electronic Health Record (PCEHR) will go some way to help alleviate some of these shortcomings, but more needs to be done.

PSA recommends the following potential project for undertaking in Tasmania:

- A pilot of a similar initiative to the one being undertaken in Cincinnati, as outlined above.

Filling rural health service gaps

Effective primary and preventive health care is dependent upon locally accessible services. Chronic diseases such as diabetes and heart disease place a significant burden on most rural Tasmanian communities. Community pharmacies are ideally placed to play a more significant role in managing these conditions within the community and to identify those most at risk.

To enable pharmacists to provide services to patients across vast distances it is important that clinical pharmacists have flexibility in their service delivery models. If multi-disciplinary healthcare teams, including pharmacists, are to deliver primary healthcare to under-served communities it is important that there is equity across the professions in the ability to claim for services provided. For example, it is important that pharmacists can be reimbursed for participating in Medical Specialist Outreach programs (MSOAP) and telehealth consultations. It is also important that pharmacists be able to dispense medicines in rural and remote clinical outposts, as can nurses and Aboriginal Health Workers. Currently legislation in many states only allows pharmacists to dispense in registered community pharmacies or hospitals.

Opportunities in Tasmania

An opportunity exists for the Tasmanian Government to collaborate with pharmacists to reduce the gap by enhancing services offered to the public in particular in rural areas. This is an opportunity to collaborate with GPs and other allied health professionals, to work together to reduce the complications and burden of these conditions on not only the individual but also the wider community.

Pharmacy has a plentiful workforce with a growing supply of well-trained graduates. Clinical pharmacists are well placed to fill gaps in primary healthcare in areas currently underserved by GPs and pharmacies, if employment and remuneration strategies are developed which enable pharmacists to work in these rural and remote areas.

PSA recommends the following potential projects for piloting in Tasmania:

- Placement of pharmacists in Aboriginal health services
- The provision to allow dispensing by pharmacists in non-S90 premises

- Remunerate rural and remote clinical pharmacists as per other health professions to allow pharmacist inclusion in multi-disciplinary healthcare teams e.g. MSOAP, telehealth.

Summary

“Effective primary and community health help to keep people out of hospitals”³⁰

It is well established that the vital service pharmacists have in dispensing and supplying essential medicines for the community, particularly consumers with chronic diseases, as part of our health system.

The existing network of 5,350 community pharmacies are uniquely placed within Australian communities (154 in Tasmania), and are increasingly being recognised as a hub for preventive health activities. However, we have yet to make full use of pharmacists in this area, nor have we leveraged the existing network and infrastructure provided by these community pharmacies to expand the scope of services that are available for consumers to assist with preventing and managing chronic diseases.

In Tasmania, where health inequalities are greatest, tapping into the skills and accessibility of pharmacists, within a collaborative framework, can assist the Tasmanian Government to achieve community health goals.

Pharmacists are accessible health practitioners who, by working within a collaborative framework, can assist Government to achieve fiscally sustainable, efficient and quality healthcare. The initiatives outlined in this submission, and the role of the pharmacist in delivering these programs, demonstrate a strong alignment with Tasmanian Government, and Department of Health objectives.

PSA Tasmanian Branch looks forward to working with the Tasmanian Government and other stakeholders to progress this project, better utilising the skills and expertise of pharmacists to address and enhance health service delivery to those in need in Tasmania.

Contact

Paquita Sutherland
Branch Director
6231 2636
Paquita.sutherland@psa.org.au

³⁰ COAG Reform Council 2014, *Healthcare in Australia 2012–13: Five years of performance*, COAG Reform Council, Sydney