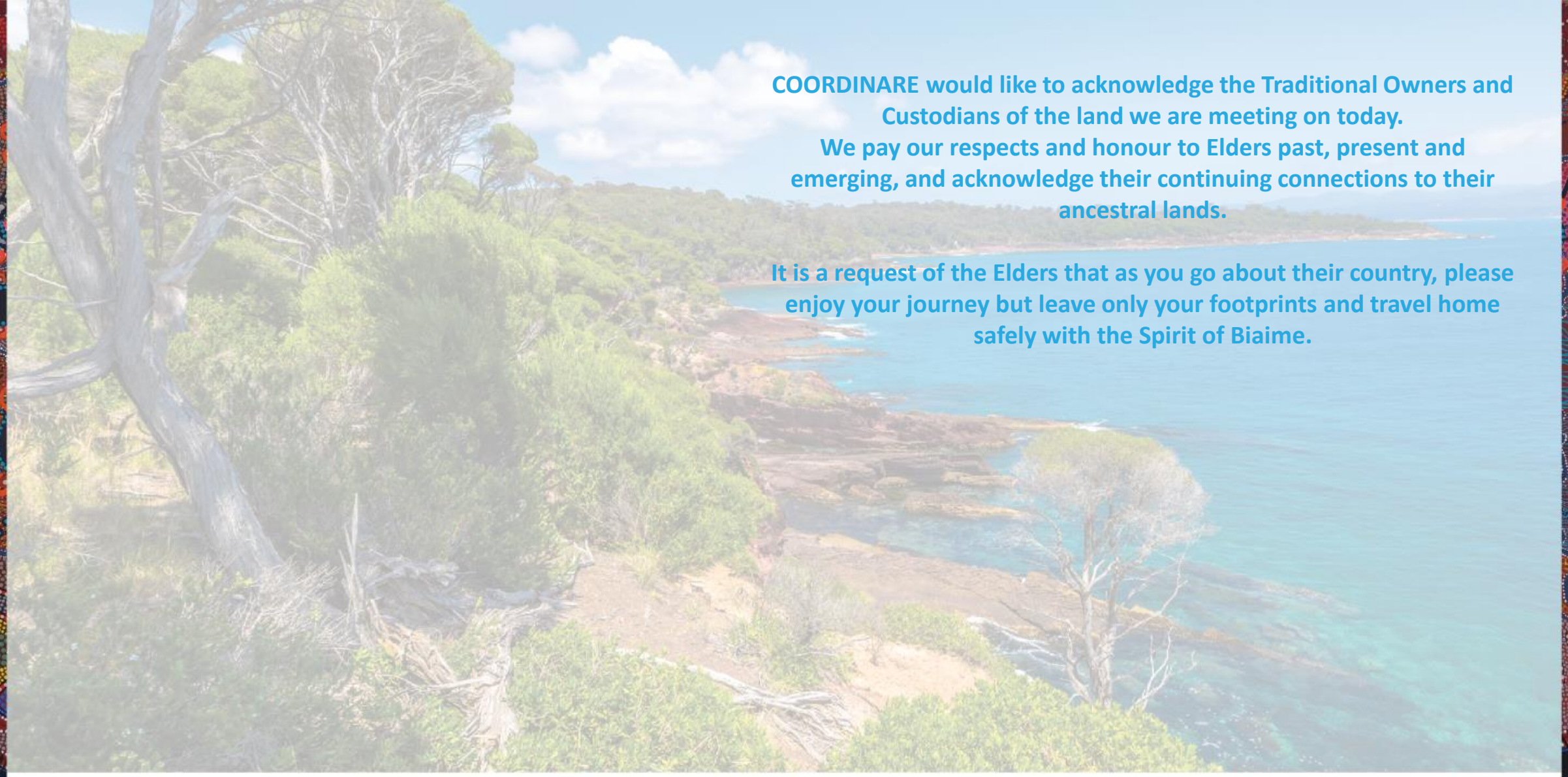
Pharmacy in the Practice
Project Update
March 2020



COORDINARE would like to acknowledge the Traditional Owners and Custodians of the land we are meeting on today.
We pay our respects and honour to Elders past, present and emerging, and acknowledge their continuing connections to their ancestral lands.

It is a request of the Elders that as you go about their country, please enjoy your journey but leave only your footprints and travel home safely with the Spirit of Biaime.

COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

Introductions

Halley Sharpe

Main Street Medical Centre in Merimbula

Jo McMahon

Queen St Medical Centre in Moruya

Caroline Abdelmasih

GP Super clinic in Queanbeyan

Margaret Jordan

Woonona Medical Practice in Woonona

Purpose

- Support practices to lead heightened quality patient care by promoting a team based care approach.
- Support practices to integrate pharmacists as part of the patient care team by developing strong working relationships with both general practice and community pharmacy.
- Assist practices to support vulnerable patients and reduce potentially preventable hospitalisations.

Objectives

- Commission general practice to integrate a pharmacist in to the practice team.
- Promote data driven care through the use of practice database interrogation to identify target population/s.
- Promote a patient centred approach to care aligned to the PCMH model of care.
- Reduce adverse drug events.
- Reduce polypharmacy.
- Support general practice with patient health literacy and enablement.

Main Street Medical Centre

Project title	
Achievements	1. Comprehensive **Medication Reviews** (including patient involvement) for 84 patients to identify areas for potential deprescribing. 1. Protocol developed and executed to identify patients who have been **discharged from hospital** that may be susceptible to medication misadventure. 1. Pharmacist led **Chronic Pain Service** involving patient education (through power point slide shown on iPad) and patient centred discussion. The aim is to promote non pharmacological methods for chronic pain management and the reduction of opioid use. **1. Disease state focus** (involving audits, medication reviews, education and health promotion) • Diabetes (Audits: Metformin and renal impairment, glitazone prescribing, Education: SGLT2 inhibitors and renal protection, Health promotion: National Diabetes Week) • AF (Audits: Non-valvular AF patients who are at risk of stroke (with appropriate CHADSVASc score) who are not currently on anticoagulation therapy, Education: Review of the audit, discussion on increased age and harm vs benefit of anticoagulant therapy, ablation therapy) • Asthma (Education: Inhaler technique, Health Promotion: Asthma Week)
Challenges	1. Initial reservation from other HMR pharmacists in the area 1. The hospital discharge protocol requiring adjustments to enable identifying ‘at risk’ patients 1. Availability of the Pharmacist, working two days a week.

Project title	
Outcomes	1. From the 79 comprehensive medication reviews, there were • 27 Medication reconciliations (34%) • 24 Reduction in medications (30%) • 16 Compliance issues to be rectified (20%) • 6 No changes (8%) • 3 Addition to medications (3%) 2. Approximately 1 patient in 7 reviewed hospital discharge papers required intervention; ranging from medication reconciliation, drug interactions and contraindications to hospital commenced medications. 3. In the 8 chronic pain consultations, there has been • Opioid dose reduction in 3 patients. • No change in opioid dose in 4 patients • Although implementation of other allied health professionals in TCA (physiotherapist, psychologist) to assist with chronic pain occurred in 3 of these patients. • Opioid dose increase in 1 patient. • Potential assistance in recognising/identifying metastasis bone pain in one patient 4. Outcomes from audits include: • Metformin and renal impairment (12 patients)- 3 patients had dose reductions or cessation of metformin therapy • Dose checks for NOACs (81 patient)- 2 patients has dose adjusted • Non valvular AF , stoke risk and not taking anticoagulants (12 patients)- 2 patients recommended to commence anticoagulants, others had risk factors and anticoagulation was against cardiologist recommendations.
Next steps	1. Incorporating inhaler technique checks into Care Plan Reviews and while waiting post influenza vaccinations (as part of ‘Flu Clinic’- Winter Strategy Project). 1. Proceed with 3 month, 6 month and 9 month post HMR reviews. 1. Increase pharmacist involvement in Case Conferences. 1. Estimation of the health care cost associated with adverse events prevented by ‘Pharmacist in Practice’ intervention (50 + clinical interventions recorded as of 31/12/2019).

Queen Street Medical Centre

Pharmacy in the Practice

Project title	
Achievements	Patient consults: deprescribing, adherence, self efficacy, opioids Post hospital reviews Audits: NOACs/ renal / PIM (potentially inappropriate medicines) Recommendations made: 698 Education sessions: NOACs / Rx in CKD / Lipids/Osteoporosis Ad hoc clinical tips: eg tamsulosin & cataract surgery Community engagement: Aboriginal health / older people & driving
Challenges	TIME pressures!! especially with consecutive PitP/GP consults Time in the day Length of project: relationship building, seeing results of inputs Change to personal work practice Practice appointment chart

Pharmacy in the Practice

Project title	
Outcomes	Improved prescribing ↑ in no. drugs with indication listed Non current meds ceased: 267 Improved patient literacy Patient information leaflets added to Best Practice: 124
Next steps	Build on deprescribing Expand education for GPs, nurses & HPs Further work on opioids, benzos, renally cleared meds Continue with audits especially PIMs Patient education eg accurate allergy understanding & documentation

Queanbeyan GP Super Clinic

Pharmacy in the Practice

Project title	
Achievements	1- Established a daily routine within the clinic by checking the discharges in the last 2 days (Project A). If they fit the criteria ,Post discharge medication review is offered. Some patients required cessing or changing of new or old medications. 2- Reviewed the medications of large number (47) of Elderly patients with impressive positive response & outcome. (Project C) 3- Successfully started Home visits for Medication Review along with GPMP and Health assessment done by the nurses. Great feedback as Elderly Patients (11so far) being reviewed by a healthcare team.
Challenges	1- Getting the discharge summaries once the patients have been discharged. The challenge was to contact the patient after he was just discharged (within1-2 days after) to get the maximum benefit. 2- Familiarise the doctors by reminding them of Utilizing the pharmacist on board for any medication enquiries also including them in decision making. 3- Corona virus situation and the advice for Elderly to stay at home while they

Pharmacy in the Practice

Project title	
Outcomes	1- Enhanced the medication compliance and understanding to the patients with big improvement in their health. 2- Excellent feedback of necessity of having the pharmacist in Practice as mentioned in the surveys done . 3-Great Functional service and Positive response of having the pharmacist with the nurse for Complete health assessment of elderly Patients at their homes.
Next steps	1- Checking if there is an opportunity of working from Home in case of Lockdown. 2- Continue to offer home medication review for most of elderly patients if they allowed it . 3- Continue with Post discharge medication review through the phone calls. 4- Start implanting education sessions for doctors in case of better control of Virus situation and as per the government guidelines.

Woonona Medical Practice

Pharmacy in the Practice

Project title	Pharmacy in the Practice
Achievements	Implementation of • pharmacist referral, patient consultation & GP-patient-pharmacist consultation integration within WMP healthcare team • systemised approach to identification and referral of patients at high-risk of medication-related adverse event • Pharmacist-led opioid stewardship project at WMP • Medication-related consultation service (Health Pathways; WMP)
Challenges	• Change of focus of project • Targeting of specific patient population (rewarding as well) • Time-constraints of GPs • Follow-up of patients • New norm of tele-health; change of priorities

Pharmacy in the Practice

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Outcomes	208 PitP referrals: 194 patients consultations (219 appointments) **High-risk patients** and **high-risk medicines** • 15 % post-hospital; mean prescribers = 2.2 (range 1 – 11) • Anticoagulant 37%; opioid 54%; sedatives 55% • Medicines reconciled: n = 2513; discrepancies: 550; range 0-13 per appt • Pharmacist recommendations 85% accepted (n = 605) **Opioid stewardship** • 96 patients: age 36 – 100 years; up to 20 years duration; 1-3 formulations • Mean oral morphine mg equivalent (OMME) before & at 8 months • 91 v 26 • Mean 47% dosage reduction; 27% no longer prescribed regular opioids
Next steps	• Finding a niche in current, changing environment • Introduction of benzodiazepine and ‘z-drugs’ policy and approach • Qualitative evaluation of practice personnel and patients