

PHARMACY REVIEW COMMENT

Carlene Smith BPharm MPS AACPA

Consultant

The following comments have been made to provide constructive information on what pharmacists do, all day, every day and to suggest additional services that could be funded to cover those items based on current services.

Community pharmacy is a valuable network of health care professionals that is often, the health hub of local communities. Over the last 10 years their ability to provide services has been seriously eroded by funding reductions, causing not only loss of self-esteem but in some cases the loss of business. These pharmacy services have been supported in the past by the remuneration received on prescriptions. As this is no longer possible, substantive changes to payment of community pharmacists must be made in order to properly remunerate pharmacists for the services they provide and make community pharmacy sustainable.

Surely no government would want to lose such a valuable, accessible health network as community pharmacy.

Where possible each service listed has been costed based on pharmacist's time or current funding model. Documentation and proof of service provided can be easily adapted to current dispensing programs

What the computer screen would look like: the patient profile would be on the screen with a drop down menu of professional services. This would provide interview forms and have the ability to upload reports.

Documentation must be simple and quickly accessed.

Example 1: if the pharmacist chose MedsCheck, a one-page interview form would be available including a place for the patient to sign. Once completed it can be scanned and uploaded.

Example 2: If the pharmacist chose HMR, then an interview form would print out, again with place for patient signature and be uploaded when complete, the HMR report can also be uploaded.

At the end of the month a report of services provided could be printed out and uploaded for payment.

Such a system would enable the pharmacist to conduct each service and provide proof the service had been completed.

A comment on pharmacist's pay

<http://www.professionalsaustralia.org.au/pharmacists/advocacy/pay-conditions/>

This article says a pharmacist starting salary is \$39,000 and is lower than any other professional. At the recent review meeting, pharmacists said they were paid \$25 per hour.....even worse. Also it notes

- The average base hourly rate has increased by 2.3% compared to 3-4% achieved by other groups; (in truth, it has probably not increased at all)
- 63% of pharmacists work through lunch, with 50% not being paid;
- 43% of pharmacists are employed as part-timers and 24% as casuals;
- 33% of Pharmacists would like more hours of work;
- 37% of Pharmacists have not had a salary review since 2009

For a graduate who has completed 4 years at University these results and conditions are appalling. For people who are considered a valuable and trusted member of the community, these numbers must be altered.

Implementation of payment for services is therefore fundamental to adequate remuneration of phrmacists.

Abbreviations used

COPD: Chronic Obstructive, Pulmonary Disease

CPA: Community Pharmacy Agreement

DAA: Dose Administration Aid

DE: Diabetes Educator

MAC: Medication Advisory Committee in Aged Care, policy making committee

MBS: Medical Benefits Schedule

NIDDM: Non Insulin Dependent Diabetes

OTC: Over the Counter

QUMAX: Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander People

RACF: Residential Aged Care Facility

PROFESSIONAL PHARMACY SERVICES (in alphabetical order)		
Please know that the services listed are the ones that I am most familiar with and I know that others will provide information on additional services that should be funded.		
SERVICE	EXPLANATION	REMUNERATION OR COST
Aboriginal Medication Review AMR	<p>This is not yet a paid service but it should be</p> <p>HMRs are listed as part of QUMAX (currently providing DAAs to aboriginal communities) but not done because of complexity.</p> <p>The pharmacist role would be the same as in an HMR (comprehensive medication review), all that would need to be altered would be no referral, but gain access to patient information and change where the report is to be sent. These reviews would not require a referral by the GP to the pharmacist.</p> <p>They could be done in liaison with Aboriginal Medical Services, when a pharmacist visited the particular area. Travel costs are an issue in remote areas and some kind of remuneration would be necessary, perhaps use the government "km payment" for public servants.</p> <p>Issues</p> <ol style="list-style-type: none"> 1. GPs not always available, use Aboriginal Medical Service or Aboriginal Health Care Workers as referral 2. The report would not always go to GP, but to the person who prescribes medications 	\$150.00 per review Plus travel
Anticoagulation monitoring	<p>This is not a paid service but pharmacists are very capable of monitoring warfarin.</p> <p>It would be a suitable monitoring service that would possibly reduce hospital admissions for patients on warfarin, and it would be cheaper for the Government than MBS to monitor.</p> <p>Based on <i>Optimising the use of antithrombotic therapy in elderly patients with atrial fibrillation</i>; Krass I; Commonwealth Department of Health and Aged Care/Quality Use of Medicines Evaluation Program.</p> <p>Research showed that pharmacists were very capable, knew what to look for and when to refer.</p> <p>http://www.utas.edu.au/umore/research/areas-of/anticoagulant-drug-therapy</p>	\$20.00

<p>Clinical Intervention CI <i>Service already in place</i></p>	<p>Clinical Interventions are currently funded un CPA.</p> <p>CPA has provided a “bucket” of money that is divided by the number of pharmacies claiming and the number of CI they claim. Can be anywhere from \$20 to \$3. The funding needs to be set in place so pharmacies can be sure of funding</p> <p>History: Based on The Promise Study</p> <p>http://6cpa.com.au/wp-content/uploads/Documenting-Clinical-Interventions-in-Community-Pharmacy-PROMISE-III-Final-Report-.pdf</p> <p>Could be divided into “simple” and “complex”</p> <p>Example of simple: Pharmacists conduct clinical interventions every day. Patient asks for over the counter eye drops. Pharmacist use “clinical decision making” to make decision that one eye that is red with pus, is not an allergy, but requires a different product.</p> <p>Obviously better for patient, from Government view, it saves MBS visit.</p> <p>Example of complex: Pharmacists conduct complex clinical interventions every day. Patient presents script from afterhours GP for antibiotics. Notes on history that patient is allergic to that particular drug, talks with patient and does not dispense script, refers to regular GP.</p> <p>Obviously better for patient, from Government view, it saves hospital admission.</p>	<p>Simple \$10.00 Complex \$20.00</p>
<p>Community Medicines Review CMR</p>	<p>Could this evolve from HMR? Done in the community pharmacy for patients who choose not to have people at their home. At present, the two criteria for having interview elsewhere is cultural and danger. Always asked for proof when application is made.</p> <p>Cultural: How do you prove a cultural issue, when name is not enough.</p> <p>Danger: if a patient does not want you in their home, by definition, the pharmacist is walking into danger and they surely will not get good information if they say they have to come to the home.</p> <p>The criteria should be widened. The following are some extra reasons that people may not want to have a pharmacist at home interview.</p> <p>Example1: a gentleman in divorce proceedings does not want any visitors to his home.</p> <p>Example 2: a lady does not want anyone to her home because he daughter just died there.</p>	<p>\$180.00 (No time spent in travel)</p>

Continued Dispensing	<p>Currently available as a service but apart from being a clunky program, the medications allowed are very limited. Would it not be better for the pharmacist to have access to a “Pharmacist script” which could be a template on the computer that just needs filling in and the patient could sign as they do with GP scripts. An automatic email could be sent to the GP.</p> <p>https://www.humanservices.gov.au/health-professionals/enablers/education-guide-continued-dispensing-initiative-pbs-requirements#a1</p>	\$20.00 to identify and evaluate and generate script
DAA for Aged Care	<p>This happens across the country, usually the pharmacy wears the cost.</p> <p>https://www.guild.org.au/docs/default-source/public-documents/tab---the-guild/Strategic-Direction/dose-administration-aids.pdf?sfvrsn=0</p> <p>Although this is a 5CPA document it is very comprehensive regarding the benefit and use of DAA.</p> <p>DAA for aged care has never been funded through Community Pharmacy Agreements. It is such a valuable service that saves medication use (by the facility only having 7 days supply on hand rather than one month) and errors in administration (staff mistakes in choosing the wrong medication are almost eliminated). Pharmacies have worn the cost by utilising the “profit” of dispensing.</p> <p>This services needs to be funded as per research</p> <p>http://www.dva.gov.au/factsheet-hsv93-dose-administration-aid-service</p> <p>Veteran Affairs has set remuneration for DAA for Veterans at \$10.00</p>	\$10 per DAA
DAA for community patients	<p>This is already a funded service</p> <p>The service involves taking a history and contacting the GP if any discrepancies... should involve a MedsCheck as well at startup.</p>	\$10.00
Delivery	<p>Many pharmacies provide home delivery services at no cost. Of course, there is a cost both in preparing the script for delivery and time spent doing the delivery.</p> <p>Some patients are unable to make even a short trip to the local pharmacy. By offering a home delivery service, elderly, chronic patients can be kept at home for longer (Government saving). This service is especially important when patients have a disability. Patient payment could be considered but most of these frail elderly patients are unable to afford to pay. Considering supermarket delivery, food delivery.... A \$5.00 fee for delivery would be a minimum fee. If it helps keep patients at home that is much cheaper for government than aged care.</p>	\$5.00 per delivery

<p>Diabetes MedsCheck <i>Service already in place</i></p>	<p>This is available as a service now but is included in capping (10 MedsChecks/Diabetes MedsChecks per month). History: http://6cpa.com.au/wp-content/uploads/Pharmacy-Diabetes-Care-Program-final-report.pdf Issues: This service works quite well if pharmacies have a private place where the interview can take place and more than 1 pharmacist on staff so there is no interruption. However pharmacists cannot always complete if patient has seen or has access to a Diabetes Educator. Many Diabetes Educators have referred the patient to the pharmacy for this service but it cannot do as DE has been seen, so have to do a MedsCheck..... Not nearly as useful. Needless to say pharmacists do talk about glucose monitoring and their diabetes medication even though they will not be remunerated. There have been quite a few research projects to show that when a NIDDM patient is monitored by a health care professional, there are better outcomes in control. Pharmacists could do this monitoring if MedsCheck D was strengthened to several visits, with download of blood glucose levels and would be more cost effective than MBS visits</p> <ul style="list-style-type: none"> • <i>SugarCare: Development, implementation and evaluation of best practice guidelines for a disease management program and professional remuneration strategy for ; Armour C, Krass I; Commonwealth Department of Health and Aged Care/Other Program and Contract Research.</i> • <i>An integrated model for disease state management (DMS) in diabetes: collaboration of the community pharmacist and GP in continuity of care; Krass I, Armour C, Taylor S; Pharmacy Guild of Australia/Research Grant.</i> <p>This service should be strengthened and broadened</p>	<p>\$94.48</p>
<p>Dispensing after hours</p>	<p>It costs much more to provide a dispensing service “after hours” rather than when staff are paid at normal rates. This could be considered when payment to the pharmacy is made. Any prescriptions dispensed after normal working hours should have an automatic addition to dispensing fee of 20%</p> <p><i>In UK, pharmacists have been given ability to prescribe after hours, have access to GP information They would need training, and mentoring but it would provide better public access and government saving</i></p>	<p>Add 20% to dispensing fee</p>

GP Surgeries/ pharmacist in attendance	<p>Currently some research is being done to provide this service.</p> <p>Background:</p> <p>Benrimoj and Whitehead about 1998 trialled such a service as research</p> <p>There have been instances of HMRs being done in GP surgeries in the past. Whether it met the criteria or not is irrelevant, it was done.</p> <p>Issues:</p> <ul style="list-style-type: none"> • Patients consider pharmacist to have a policing role. • Possibility of change in relationship between GP and patient. • Because reports mostly verbal and are done quickly at the time of visit, it is hard for GP to go back and re-evaluate issues • Pharmacist conducting the review only has GP information, no pharmacy information and no information on what patient has at home. <p>Whilst this can be classed as a medication review, any report will only be relevant to information from one source. It would also involve back filling at the pharmacy so the pharmacist can be offsite.</p> <p>Could be more of a MedsCheck S (for a MedsCheck at the Surgery).</p>	\$150.00
Graduate Preceptor	<p>Pharmacists do this already and are not funded in any way.</p> <p>When a pharmacist finishes their University degree that have to complete 2000 hours under the supervision of a pharmacist preceptor. Working in Community pharmacy can give the new graduate an overview of legal and ethical responsibilities while under the supervision of a mentor. The following article is about interns and GP practices, similar values can apply to pharmacy.</p> <p>https://www.mja.com.au/journal/2007/186/7/general-practice-placements-pre-registration-junior-doctors-adding-value-intern</p>	\$2,5000.00 per graduate, per year
Home Medicines Review, HMR <i>Service already in place</i>	<p>GP referral/ community pharmacy (who contracted or employed an accredited pharmacist)/ Home interview/report to GP</p> <p>HMR started life as DMMR (as distinct from RMMR), no one could spell Domiciliary and some thought it had something to do with Dept Main Roads. Changed by Public Servant to Home Medicines Review (Home because it was about patients at home, medicines to include complementary, herbal and OTC)</p> <p>GP Fee based on 2 visits, only claimed via Medicare on completion</p> <p>Ph fee based on 3.5 hours work</p> <p>Rules: http://6cpa.com.au/medication-management-programmes/home-medicines-review/</p>	\$210.93

	<p>History: Based on <i>A comparative study of two collaborative model for the provision of domiciliary medication review</i>; Chen T, Hurst R; Commonwealth Department of Health and Aged Care/Guild/Government Agreement.</p> <p>Several models were tested at the same time by Professor Mike Roberts, Queensland and Professor Andy Gilbert, South Australia.</p> <p>Issues: Changes made to allow accredited pharmacists to claim without going through community pharmacy, put accredited pharmacists in competition with community pharmacists.</p> <p>Accredited pharmacists did not often contact the pharmacy who was doing the dispensing. Community pharmacists have seen accredited pharmacist take their hard won professional services business because they encouraged the GP to deal direct. Community pharmacists had their business taken away from them and do not have time or heart to fight.</p> <p>In UK, they provide an optimisation service which is not as comprehensive http://www.boots.com/en/Pharmacy-Health/Health-pharmacy-services/Pharmacy-services-support/I-have-a-prescription/Medicine-checks/Medicine-Optimisation/</p> <p>Australia was the first country in the world to have a medication review service with the patient at the centre. Community pharmacy does not have the capacity to do these reviews due to reduced staff, due to reduced remuneration.</p> <p>Evidence of HMR benefit</p> <p>We know medication reviews are useful.....</p> <p>Professor Andy Gilbert and Libby Roughead has access to data from Veterans Affairs and were able to track event, costs or Veterans before and after HMR.</p> <ol style="list-style-type: none"> 1. Roughead, EE, Barratt, JD, Ramsay, E, Pratt, N, Ryan, P, Peck, R, Killer, G & Gilbert, AL 2010, 'Collaborative home medicines review delays time to next hospitalization for warfarin associated bleeding in Australian war veterans', <i>Journal of Clinical Pharmacy and Therapeutics</i>. 2. Kalisch Ellett, LM, Roughead, EE & Gilbert, AL 2010, 'Improving heart failure outcomes with pharmacist-physician collaboration: how close are we?', <i>Future Cardiology</i>, v. 6, no. 2, pp. 255-268. 3. Roughead, EE, Barratt, JD, Ramsay, E, Pratt, N, Ryan, P, Peck, R, Killer, G & Gilbert, AL 2009, 'The Effectiveness of Collaborative Medicine Reviews in Delaying Time to Next Hospitalization for Patients With Heart Failure in the Practice Setting', <i>Circulation: Heart Failure</i>, v. 2, pp. 424-428. 	
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	<p>UK medication reviews</p> <p><i>A bit of history: UK had pharmacists in GP surgeries to help them stay within their NHS budget, when they saw how useful HMR was in Australia they changed focus and now have 5 different types of review.</i></p> <p>UK interventions showed that of 314 interventions, 80 hospital admissions were avoided</p> <p>Different types of medication review in UK http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3477324/</p>	
Hospital to Community Link	<p>Pharmacies are often asked to repack medicines both for community and aged care patients after discharge from hospital. This involves checking with GP, getting a script for new meds/changes and then repacking. GPs are often understandably uncooperative because they have not seen the patient. Sometime the patient simply continues to take the medicines and lands back in hospital.</p> <p>At present there is no authority for a hospital doctor or RN to ask a community pharmacy to change or repack medicine, it must be authorised by the patient's GP.</p> <p>Consider providing a hospital script authorising the pharmacy to repack for one week so it gives the patient time to get back to GP.</p> <p>This would save the hospital dispensing a useless amount of medication that does not correspond with anything the patient is currently taking, causing confusion. It would allow the medicines to be repacked as the hospital staff wanted and give the GP time to see the patient to either continue or not.</p> <p>Issues in communication from hospital: The list of medicines from hospital is usually about dealing with the acute event that has taken place and is often incomplete and sometimes incorrect.</p> <p>If the hospital had the ability to direct the pharmacy for that acute event, then pharmacy could claim on that script. Many of the problems that are occurring would be avoided, improving patient benefit, perhaps reducing readmissions.</p> <p>Sometimes GPs do not know that their patient has gone to hospital. Certainly the pharmacy does not know. There must be documentation (eg automated email) letting the patients' health care professionals know (so medicine pack can be suspended, delivery suspended) when patient is in hospital. When the patient is discharged, another email would allow care at home to begin again, which would also help implement what the hospital doctors think should happen.</p> <p><i>See HCML report for HMRs/ heart failure patients helping to reduce readmission rates</i></p>	Dispensing fee as per NHS

Language Support	<p>Currently there are many pharmacies who provide staff who speak a language other than English, which is fully funded by the pharmacy. This is an excellent service to patients who are sometimes elderly and frail, to help explain prescription medicine.</p> <p>The remuneration suggested does not “pay” for the staff member but is recognition that this staff member will be needed to do language duties rather than retail duties. If fact, it may mean that the pharmacy needs another member of staff to compete retail tasks.</p>	\$1000.00/year
MedsCheck <i>Service already in place</i>	<p>Pharmacists often spend a large amount of time talking with patient about their conditions and the medicines they use. This is often not always counselling and MedsCheck was supposed to remunerate pharmacists for this service. Pharmacists lost interest in the service when funding was capped to 10 per month and they could not justify an extra pharmacist on staff to provide capacity. It does not mean they stopped talking to patients, it just means they are not paid for that service.</p> <p>MedsCheck started out quite well with training for pharmacists to help them manage the MedsCheck interview and documentation. Currently under cap system of 10 per month includes Diabetes MedsCheck). Very few pharmacies are conducting the service because it is uneconomical to provide a pharmacist on staff to just do 10 per month.</p> <p>History http://6cpa.com.au/medication-management-programmes/medscheck-diabetes-medscheck/ </p> <p>It was considered that 30 mins is valuable to patients to help their understanding and improve compliance.</p> <p>Issues: Guild Care provided a computer program which unfortunately caused other programs to slow down. Systems need to be added to dispensing software as suggested.</p>	\$62.99
MedsCheck A Asthma	<p>Pharmacists do spend time with asthma patients although there is no requirement now that the asthma card has been stopped so it is up to the patient in how much information they receive.</p> <p>This is not yet a funded service but MedsCheck could easily be adapted to deal with chronic condition.</p> <p>Much work has been done in community pharmacy with asthma patients but the pharmacy services have disappeared with disastrous results for patients. There is evidence that most people get their information re puffers and treatment from pharmacists rather than hospitals or GPs.</p>	\$94.48 Same as Diabetes MedsCheck

	<p>Why is there not ns Asthma Service? With evidence that patients are not using the myriad of puffers correctly would it not be useful to have a health care professional such as an accessible community pharmacist involved. How many hospital visits could be saved?</p> <ul style="list-style-type: none"> Pharmacy Asthma Action Plan Program- Pharmacists addressing the issues in the community; Krass I, Saini B, Bosnic-Anticevich S, Armour C; NSW Department of Health/Research Grant. Managing Asthma in Rural Communities; Armour C, Saini B, Bosnic-Anticevich S, Krass I, Taylor S, Dalton A, Hulme F; Commonwealth Department of Health and Ageing/Research Grant. LeMay, K., Saini, B., Bosnic-Anticevich, S., Smith, L., Stewart, K., Emmerton, L., Burton, D., Krass, I., Armour, C. (2015). An exploration of clinical interventions provided by pharmacists within a complex asthma service. <i>Pharmacy Practice</i>, 13(1), 1-8 	
MedsCheck H	<p>Pharmacists are often asked to spend time with a patient that has returned from hospital. This could be the service completed when a patient is discharged from hospital</p> <p>Pharmacists will always tell you the stories when a patient comes in at closing time with 6 inadequately labelled medications that bear no resemblance to what they are taking. It might take 30 minutes and 2 phone calls but pharmacists will sort them out.</p> <p><i>In UK, they found that pharmacists visiting a discharged patient 3 times in 90 days provided good outcomes. Could this initial MedsCheck lead to an HMRH, Home Medicines Review post discharge.</i></p>	<p>\$94.48</p> <p>Same as</p> <p>Diabetes</p> <p>MedsCheck</p>
MedsCheck M	<p>Mental Health patient have often taken a lot of the pharmacist's time in the pharmacy and they are not remunerated for that time. Patient's need to be sure their medicines are going to do what they want. They are sometimes in a difficult frame of mind and need careful communication.</p> <p>Could we not use the MedsCheck program and use it to help Mental Health patients</p> <p>This service does not exist but it should.</p> <p>Much work has been done to provide pharmacists with extra communication skills to help those patients with mental illness and the feedback from patients in the research was very positive</p> <p>http://www.mentalhealthproject.com.au/documents/</p>	<p>\$94.48</p> <p>Same as</p> <p>Diabetes</p> <p>MedsCheck</p>
MedsCheck N	<p>Pharmacists often spend time with patients who have had new medicines prescribed.</p> <p>This could be a service where a new medicines has been prescribed and the pharmacist takes time to explain, pharmacists do this now so it simply formalises the service. In UK, see below</p>	<p>\$25.00</p>

	http://www.boots.com/en/Pharmacy-Health/Health-pharmacy-services/Pharmacy-services-support/Medicine-checks/New-medicine-service-NHS/	
Minor Ailments	<p>Pharmacists are always giving advice about minor ailments with no remuneration apart from the profit on the sale (or not if no product is sold)</p> <p>Pharmacists can provide this service. If patients went to a GP for these minor ailments it would cost MBS a lot more.</p> <p>In Britain http://www.boots.com/en/Pharmacy-Health/Health-pharmacy-services/Pharmacy-services-support/I-need-more-information/Minor-ailments-service-NHS/</p> <p>This is how the process is set up in UK</p> <p>http://www.miltonkeynesccg.nhs.uk/community-pharmacy-locally-commissioned-services</p> <p>http://www.rpharms.com/promoting-pharmacy-pdfs/ue-care---good-practice.pdf</p>	\$10.00 per item
Morning After Pill	<p>This is a valuable service where young women can have access to the morning after pill through community pharmacy. Currently not utilised very much due to complex questions to patient.</p> <p>In UK</p> <p>http://www.boots.com/en/Pharmacy-Health/Health-pharmacy-services/Pharmacy-services-support/I-need-more-information/Morning-after-pill/</p>	\$20.00
Needle and Syringe Program	<p>This service exists</p> <p>History:</p> <p>https://www.health.gov.au/internet/main/publishing.nsf/Content/73934F5307F88EC7CA257BF0001E009F/\$File/ques.pdf</p> <p>Pharmacists are under an obligation to “watch” the person place the used syringes in the sharps bins. This is a valuable service to the community and has helped keep the community safe from HIV and Hepatitis.</p>	\$500.00 per year
Opioid Substitution	<p>Many pharmacies provide this service and it is partly funded by the patients @ \$5.00 per dose</p> <p>Pharmacists have to train, prepare, administer and followup these patients. It is a very worthwhile service for the community. Often the community pharmacist is the first person with whom the addict has formed a normal relationship.</p> <p>Dose reductions leading to normalisation of life, enabling work etc to be done is a valuable community service.</p> <p>The pharmacists have to do 2 hours mandatory training per year</p>	<p>Set up \$300</p> <p>Dose fee \$5.00</p>

Quality Use of Medicines, QUM <i>Service already in place</i>	<p>This is a valuable free service to Residential Aged Care Facilities, can be done by a community pharmacist. Involves medication surveys (eg charts, trolley, labels, benzodiazepines, psychotropic); education of staff (short 30 minutes sessions); Nurse Initiated Medication lists; Emergency Medication; Attendance at MAC meetings;</p> <p>Rules: http://6cpa.com.au/medication-management-programmes/residential-medication-management-review/</p> <p>History: Based on Medication used in aged care hostels: A team approach applied to defining and optimising quality drug use in residents of aged hostels (1997) Professor Mike Roberts UQ</p> <p>Issues: Funding has not increased in 20 years, sometimes not enough time is spent by those who currently have contracts. Sometimes the service is not done regularly and no one seems to check.</p> <p>Pharmacist who is at facility needs to be “backfilled” at pharmacy.</p>	\$240 plus \$6 per bed per quarter
Referral to GP	Any of the above scenarios can result in a referral to the patient’s GP. Would involve a short letter to GP with explanation, again would be a template on computer that could be logged and printed out.	\$10.00
Residential Medication Management Review, RMMR <i>Service already in place</i>	<p>Residential Aged Care Facilities use this service at no charge to provide proof of QUM for their accreditation.</p> <p>Rules: http://6cpa.com.au/medication-management-programmes/residential-medication-management-review/</p> <p>History: Based on Optimisation of quality drug use in the elderly in long term health care facilities by Professor Mike Roberts UQ</p> <p>Issues: Mostly conducted by companies who provide accredited pharmacists, “fly in fly out” with no connection or communication to the pharmacy that does the dispensing.</p> <p>Community pharmacies are much better placed to understand resident issues and improve medicine use when they dispense for the facility. They already have a relationship with GP and can be involved with ongoing follow up.</p>	\$106.66
Return of Unwanted Medicine RUM	Pharmacies provide a RUM Bin to help remove unwanted medicine from the community <i>Order it, make space for bin, explain to patient what happens, phone to have bin removed</i>	Annual fee
Rx medication charts	<p>http://www.rxmedchart.com.au/</p> <p>This is a new service which can save time for</p> <ol style="list-style-type: none"> 1. RACF, no need to have GPs write scripts any more, the chart is the script. Clear, typed charts, no more reading errors by staff. 2. GPs, only one item to write rather than scripts as well as chart 	Annual cost \$50 per resident

	<p>3. Pharmacy, no more scripts owing, no more chasing GPs for scripts</p> <p>Nevertheless, it does cost money and while facilities are encouraged to contribute, they often do not as they are also in cost cutting mode.</p> <p>Time taken, set up costs quite high (\$1500.00) with new computer hardware, software and communication updates from GPs and staff. Cost of charts is \$3.00 per resident per month</p> <p>The cost is minimal compared to hospital visit or GP visit and the service should be funded</p>	
Screening	<p>This service used to be in the 5CPA but is not in 6CPA. Such a valuable service where the community is screened for blood pressure, blood glucose, COPD, AF, Asthma puffer check, weight etc and if required, are referred back to their GP.</p> <p>Great community benefit as often people are unaware of problems</p> <p>History: <i>Based on</i> <i>Teh, R., Chen, T., Krass, I. (2001). Consumer perspectives of pharmacist-delivered health information and screening services. International Journal of Pharmacy Practice, 9, 261-267.</i> <i>Development, implementation and evaluation of a health promotion and screening service in community pharmacy; Krass I, Smith D, Chen T; Commonwealth Department of Health and Aged Care/Guild/Government Agreement.</i> <i>In UK: COPD: West Yorkshire in UK targeted high risk patients and followed over 4 months</i> http://www.cpw.org/pharmacy-contracts-services/localservices-enhanced-/respiratory-epic-.shtml</p> <p>If one person is found with high blood pressure and can be treated, it can stop them having a stroke and becoming a cost to the community.</p> <p>If one person is found with COPD and is then treated it can help them stay in the workforce longer.</p>	<p>\$10.00 per screen \$300 for 3 promotions per year</p>
Student Placement	<p>Pharmacists take students to give them experience in the real world. This involves some structured learning for the student but most times the pharmacist is expected to “teach” the student about everyday life and management in a pharmacy.</p> <p>Student placements equate to about 100 hours each year of pharmacist time for every student placement. Is it beneficial? Of course it is as it enables the student to become familiar with his or her future workplace and benefit from real life mentoring.</p>	<p>\$1,000.00 per student/year</p>

	If the Government had to pay for this time via University teaching, the cost would be much greater. As remuneration has decreased it has become much harder for universities to place students.	
Surgery Medication Review SMR	<p>This service does not exist but it could</p> <p>Again an evolution from HMR where the pharmacist conducts the same medication review as in an HMR but the interview and report is done at the GP surgery.</p> <p>Often these reviews in the past have been done but have not had a written report but a verbal report to GP. This service must have a written report, exactly as an HMR.</p>	\$150.00 No travel