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Review panel
Review of Pharmacy Remuneration and Regulation

Re: Discussion Paper for Review of Pharmacy Remuneration and Regulation 2016

Dear Panel members,

I am writing in regard to question number 7 under the section Regulatory Landscape, Community Pharmacy Agreement (CPA) in the Discussion Paper i.e. Should the CPA be limited to dispensing and professional programs provided by community pharmacy only? If so, how can contestability and effectiveness be ensured in professional programs? If not, why not?

The view of RDNS is that the CPA should not be limited to professional pharmacy programs provided by community pharmacies only. We believe that there is a need for innovative, patient-centred professional pharmacy programs to be delivered in a range of settings and circumstances beyond community pharmacies, as outlined in our response below.

The RDNS is Australia’s largest independent, not-for-profit community nursing organisation. Our nurses provide approximately 2.7 million of home visits and care to more than 100,000 Australians annually.[1] Over 50% of our nurses’ visits are to provide medication management support when people are unable to manage their medicines independently, due to decline in health and/or cognitive function. Our clients are typically frail, house-bound older people with complex health conditions who are at high risk of experiencing medication issues because they have multiple prescribers and take multiple medications (average 80 years, 5 chronic conditions and 10 medications).[2] Research conducted within our organisation has revealed that medication errors and adverse medication events requiring hospitalisation or medical consultation were common in community nursing clients, affecting 41% and 13% clients respectively.[2] A majority of the adverse medication events (64%) were potentially avoidable.[2]

Reasons for the high incidence of medication errors and adverse medication events have been identified and include poor access to interdisciplinary medication review, inadequate teamwork and communication in medication management between members of the healthcare team, and other systems issues.[2] As many of our clients are housebound, the MedsCheck service that is delivered within community pharmacies is not an accessible or suitable option, and only 5% of clients referred to RDNS for medication management support receive an Home Medicines Review (HMR).[2] Many barriers to HMR have been identified including the complex process for the HMR model and low participation rate from GPs.[3-8] Various attempts to increase HMR uptake, including strategies specifically targeting community nursing clients, have been unsuccessful.[8] Furthermore, the HMR model has limitations and usually does not address the specific needs of this complex client group and the health professionals involved in their care. For example, community nurses are not involved in the HMR process, and their needs in the provision of medicines management
support are often not addressed by HMR. Another limitation of HMR is that it is a one-off service with no follow up to ensure that medication-related problems are resolved, and to assist with implementing changes to the medication regimen. There is also no formal relationship between the consultant HMR pharmacist and the community nurses.[9]

Recently RDNS Institute and Monash University Centre for Medicine Use and Safety piloted a new model in which clinical pharmacists were employed to work within the community nursing service.[1] The role was designed to provide medicines management support for community nurses, clients, carers and their health providers (GPs, specialists, community pharmacies). Their role included undertaking home visits with community nurses, to review and reconcile clients’ medicines and obtain accurate medication histories, and working with community nurses, prescribers and community pharmacies to optimise and simplify clients’ medicines to ensure safe medicines administration by community nurses, clients and their carers. Follow-up reviews and/or visits were provided where necessary. The pharmacist also provided other support to the community nurses included answering medicines information queries, providing nurse education, developing resources to support safe medication management for nurses and providing advice on medication-related policies and procedures.

Findings from our pilot study demonstrated that our model was well accepted and highly valued by nurses, clients, carers, GPs and community pharmacists – a higher uptake by clients and nurses compared to the HMR model and also improvements in medication safety and patient outcome and interdisciplinary teamwork.[9 10] Factors driving the success of our model compared to the HMR model were identified.[9] A cost analysis revealed that the RDNS-employed pharmacist model has potential to generate greater savings to the healthcare system than the HMR model. Cost-savings include reduced medication costs, RDNS nurse home visits, GP costs and hospitalisation costs.[11] Our findings indicate that there is a need for new collaborative, interdisciplinary models to provide safe and effective person-centred medicines management service for frail, older people who receive home nursing services; and a need for funding to support translation of our model.

Based on evidence from our work, professional programs for pharmacist services should not be confined to community pharmacies. The funding and service delivery models for pharmacist services should be flexible, to enable organisations like RDNS to access Commonwealth funds for pharmacist medication management services for their clients. This will help to ensure these services target patients at greatest risk of adverse medication events and are tailored to their needs. Based on our model, using employed pharmacists, rather than private ‘consultant pharmacists’ (which is currently used in the HMR model), could enable medication review services to be delivered more efficiently and enable more at-risk clients to have access to pharmacist medication management services.

Thank you very much for reviewing and considering our response.

Yours sincerely,
Professor Colette Browning
Director
Royal District Nursing Service (RDNS) Institute
Honorary Professor Peking University
Adjunct Professor Monash University

RDNS | [redacted]
References
6. Swain L, Barclay L. Medication reviews are useful, but the model needs to be changed: Perspectives of Aboriginal Health Service health professionals on Home Medicines Reviews. BMC health services research 2015;15:366 doi: 10.1186/s12913-015-1029-3[published Online First: Epub Date]].