

Pharmacy Trial Program Tranche 2

Integrating Pharmacists within ACCHSs to Improve Chronic Disease Management (IPAC) Project

Support for Pharmacists

June

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The financial assistance provided by the Australian Government must not be taken as endorsement of the contents of this report. The trials are undertaken by independent researchers and therefore the views, hypotheses and subsequent findings of the research are not necessarily those of the Australian Government Department of Health.

Abbreviations

ACCHO	Aboriginal Community Controlled Health Organisation
ACCHS	Aboriginal Community Controlled Health Service
AHS	Aboriginal Health Service
AHW / ATSIHP	Aboriginal Health Workers/Aboriginal and Torres Strait Islander Health Practitioners
AMH	Australian Medicines Handbook
APF	Australian Pharmaceutical Formulary
CIS	Clinical information system
CKD	Chronic Kidney Disease
HMR	Home Medicines Review
IPAC	Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management
JCU	James Cook University
MAI/AOU	Medication Appropriateness Index/Assessment of Underutilisation
MBS	Medicare Benefits Schedule
N-MARS	NACCHO Medication Adherence Readiness Scale
NACCHO	National Aboriginal Community Controlled Health Organisation
PBS	Pharmaceutical Benefits Scheme
PSA	Pharmaceutical Society of Australia Ltd.

Executive Summary

Introduction

Historically, a small number of Aboriginal Community Controlled Health Services (ACCHSs) across Australia have considered the need to improve chronic disease management and prescribing quality and sourced ad-hoc funding to support the role of an integrated pharmacist. However, these appointments remain few in number and there is no national support program for these roles.

The majority of integrated pharmacists participating in the IPAC Project had no prior experience working with ACCHSs and Aboriginal and Torres Strait Islander clients. Although induction training was specifically developed to ensure pharmacists had adequate cultural, clinical and technical skills, it was acknowledged that the integrated pharmacists would predominantly be working in physical isolation from their professional peers. Moreover, given the relative novelty or 'newness' of the role it was anticipated by the Project Team that substantial support would be needed in order for participating pharmacists to integrate effectively within their respective ACCHSs, understand and conduct core roles, and enter data essential for project evaluation.

Methods

Following induction training, a multifaceted and tailored program of support was provided to the integrated pharmacists throughout the project's implementation phase. Support methods included phone and email support from the Project Team, comprising representatives from PSA, NACCHO and JCU, as well as formal and informal mentoring by experienced Aboriginal Health Services pharmacists. Substantial further support was provided by means of site visits by PSA Coordinators, participation in regular monthly teleconferences, inclusion in an online discussion group and contact by closed-group social media. The integrated pharmacists were also given access to a contemporary online repository of resources related to medicines use and management of chronic disease in Aboriginal and Torres Strait Islander peoples, taking into account jurisdiction-specific differences in legislation and best-practice guidelines. PSA's Project Coordinators, who had considerable combined experience conducting medication management reviews as well as undertaking review and implementation of program delivery to the Aboriginal Health Service sector, were primarily responsible for coordinating and managing the delivery of these support measures.

Results

Throughout the project's implementation phase, significant uptake and consistent utilisation of the various platforms of support provided to the integrated pharmacists was demonstrated (see Table 1)

Table 1 - IPAC Project utilisation of support platforms

Support platform	Frequency
Site visits by PSA Coordinators	20 site visits across 16 ACCHSs
Monthly teleconferences	11
Discussion Forum	91 unique topic threads
Social Media (WhatsApp®)	530 individual messages
Mentor Program Support	11 formal + 3 informal agreements

Regular communication by phone or email occurred between PSA Coordinators and integrated pharmacists. The integrated pharmacists contacted PSA Coordinators for support on at least a daily basis. The significant perceived value of support received by the integrated pharmacists from PSA Coordinators and the Project Team was evidenced by means of feedback received during the project's qualitative evaluation. The importance of support was further reinforced during a workshop held at the end of the project to explore the many enablers and challenges experienced by the integrated pharmacists as they undertook their professional activities.

During site visits to participating ACCHSs, the PSA Coordinators observed a strong sense of teamwork and collaboration between the integrated pharmacists.

Discussion

The value of the support received by integrated pharmacists in the IPAC Project was clearly validated by several measures, including qualitative evaluation, personal and face-to-face communication with integrated pharmacists and frequent use of Project Team's expertise and platforms.

The methods to support pharmacists during the IPAC Project were acceptable and effective across a wide range of healthcare settings. Integrated pharmacists' utilisation of the various means of support on offer differed according to personal preference and ease of access from their respective ACCHSs. The combination of scheduled and ad-hoc opportunities to communicate with PSA Coordinators and colleagues, as well as the option to connect by a variety of electronic platforms, meant that the integrated pharmacists could identify and use the method best suited to their individual circumstances.

Given the geographic spread of ACCHSs around Australia and the relative novelty of the integrated pharmacist role in this sector, it is expected that effective support will be required for integrated pharmacists to adapt to new healthcare activities and workflow and to overcome feelings of professional isolation. We propose that the support methods used in the IPAC Project are generalisable for application in a national program that supports the integration of pharmacists into ACCHSs.

Conclusion

Substantive and considered support for pharmacists integrated within ACCHSs is essential to enable effective delivery of medicines-related services through a coordinated and collaborative approach to improve the quality of care received by Aboriginal and Torres Strait Islander patients. Indeed there is a risk that integrating pharmacists into ACCHSs without adequate support may limit the uptake and effectiveness of an integrated pharmacist service.

Support for integrated pharmacists may be provided by various means as demonstrated in the IPAC Project, and should involve multi-modal strategies to take into account accessibility, ease of utilisation and responsiveness. Beyond the IPAC Project, provision of adequate training and support, along with the creation of a community of practice for pharmacists working with Aboriginal and Torres Strait Islander peoples, will enable sharing of sector knowledge and expertise with the aim of increased uptake, up-skilling and retention of pharmacists working in the ACCHS sector.

Recommendations

Table 2 - Recommendations for support needed for integrated pharmacists in the ACCHS sector

Support needed for integrated pharmacists	Resources required for implementation	Intended industry impacts – Implementing this recommendation will lead to:
<p>1/ Establish a program to provide ongoing support to integrated pharmacists working (or intending to work) in the ACCHS sector</p>	<p>Pharmacist ACCHS Support Program role will:</p> <ol style="list-style-type: none"> 1.1 Facilitate access to training pathways for pharmacists commencing work within ACCHS. 1.2 Provide a clinical mentoring service. 1.3 Coordinate a mentoring program for pharmacists commencing working in the AHS sector to connect with pharmacists with prior experience. 1.4 Maintain a contemporary online repository of resources related to medicines use and management of chronic disease in Aboriginal and Torres Strait Islander peoples. 1.5 Coordinate a “community of practice” utilising a range of tools to connect integrated pharmacists in the AHS sector eg facilitated online discussion forum, social media, gathering at forums. 	<ul style="list-style-type: none"> • Enhanced support for pharmacists working (or intending to work) in the ACCHS sector, with resultant increase in available workforce of AHS pharmacists • Increased access to integrated pharmacist services by Aboriginal and Torres Strait Islander peoples with chronic disease • Increased retention of integrated pharmacists due to reduced feelings of professional isolation in the ACCHS workplace • Enhanced sharing of professional expertise between AHS pharmacists, with resultant up-skilling of integrated pharmacists working in the ACCHS sector

Support needed for integrated pharmacists	Resources required for implementation	Intended industry impacts – Implementing this recommendation will lead to:
2/ Promote availability of relevant continuing professional development (CPD) for pharmacists working in the ACCHS sector	2.1 Provision of accredited CPD activities related to Aboriginal and Torres Strait Islander health care, for inclusion in pharmacists' annual CPD plans	<ul style="list-style-type: none"> • Continuous improvement in the quality of care provided by pharmacists to Aboriginal and Torres Strait Islander Australians.

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1. Introduction

Aboriginal and Torres Strait Islander peoples experience a much higher burden of chronic disease due to cardiovascular disease, diabetes, and other health problems, and yet have poorer access to needed medicines compared to other Australians.¹ Adverse health outcomes from these illnesses are preventable if prescribing quality is improved, and patients are better supported with medicines use, which is a key health equity issue. There is extensive global evidence that integrated pharmacists co-located within general practice clinics can enhance chronic disease management and quality use of medicines.²

The Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease Management (IPAC) Project was developed to explore if integrating a registered pharmacist as part of the primary health care (PHC) team leads to improvements in the quality of the care received by Aboriginal and Torres Strait Islander peoples with chronic diseases.

Historically, a small number of ACCHSs across Australia have considered the need to improve chronic disease management and prescribing quality and sourced ad-hoc funding to support the role of an integrated pharmacist. However, these appointments remain few in number and there is no national support program for these roles.

The majority of integrated pharmacists participating in the IPAC Project had no prior experience working with ACCHSs and Aboriginal and Torres Strait Islander clients. Although induction training was specifically developed to ensure pharmacists had adequate cultural, clinical and technical skills, it was acknowledged that the integrated pharmacists would predominantly be working in physical isolation from their professional peers. Moreover, given the relative novelty or 'newness' of the role it was anticipated by the Project Team that substantial support would be needed in order for participating integrated pharmacists to integrate effectively within their respective ACCHSs, understand and conduct core roles, and enter data essential for project evaluation.

2. Methods

Throughout the IPAC Project implementation phase, support was provided to the integrated pharmacists by various means, including (but not limited to) phone and email support by PSA Coordinators and the wider Project Team, formal and informal mentoring, site visits, access to online resources, regular monthly teleconferences, an online discussion group and contact by closed-group social media. PSA's Project Coordinators, who had considerable combined experience conducting medication management reviews as well as undertaking review and implementation of program delivery to the Aboriginal Health Service sector, were primarily responsible for coordinating and managing the delivery of these support measures.

2.1 Phone and email support

Induction training for the integrated pharmacists included a session dedicated to communication processes, during which instructions and relevant contact details were given for use in the event of queries related to:

-
- Information technology (clinical information/software systems, pharmacists' electronic logbook, GRHANITE™ data extraction, online access to PSA's IPAC Project related resources)
 - Clinical information
 - Personal and annual leave requests
 - Conflict resolution

Throughout the intervention phase of the project, integrated pharmacists were able to contact the project coordinators from PSA, NACCHO and JCU via phone or email during business hours, enabling prompt response to queries.

2.2 Site visits by PSA Project Coordinators

While the Project's protocol suggested that the initial site visit by PSA Coordinators would coincide with on-site induction training for integrated pharmacists at their respective ACCHSs, the decision to provide induction training by means of group workshops in Sydney, Melbourne and Brisbane meant that site visits would be more purposeful if conducted after the integrated pharmacists had commenced work. PSA Project Coordinators therefore aimed to conduct a site visit to all participating ACCHSs within the implementation period to assist with monitoring performance and most importantly to provide support to integrated pharmacists to help them achieve their role.

During site visits, Coordinators conducted a physical inspection of the pharmacist's work space to observe their access to a computer and private space for patient consultations, proximity to GPs and other allied health providers, proximity to the patient waiting room, access to professional references and use of IPAC Project promotional materials.

A large proportion of the site visit time was spent meeting with the integrated pharmacist to explore and discuss matters such as;

- Availability of an IPAC Project 'go to' person at the ACCHS – who is this? Has this changed? If so, how many changes to date and how has this impacted the project?
- Referral process - How are patients referred to the pharmacist?
- Consent process – How is patient consent obtained? Number of consented participants to date, possible reasons why some patients decline to consent, likelihood of targets being met.
- 'A day in the life' of the integrated pharmacist – How much time (on average) is spent both undertaking and logging data for patient recruitment/consent and core roles including HMRs, Non-HMRs, follow-up to HMRs & Non-HMRs, N-MARS, MAI/AOU, team meetings, drug utilisation review, preventive health activities, education & training, medicines information service, liaison with community pharmacy and transitional care?
- Performance review – comparison between electronic logbook data vs Pharmacist Activity Workplan, personal expectations, troubleshooting to identify areas needing revision of training, or additional support.

A meeting was scheduled in advance with the IPAC Project 'go to' person at each ACCHS to talk informally about their overall satisfaction with the integrated pharmacist, how the integrated pharmacist interacted with colleagues and patients, and the integrated pharmacist's input into clinical care and services for which MBS payments may be claimed. They were also asked to comment on their overall satisfaction with the project to date, their thoughts regarding continuity of the integrated pharmacist role after the conclusion of the project, and any suggested areas for improvement or additional support to be provided by PSA or an alternate body.

The PSA Coordinators were also available during the site visit to meet opportunistically with other ACCHS staff such as GPs, AHWs, nurses and clinic managers to seek informal feedback on their experiences with the project and integrated pharmacist to date.

2.3 Online resources repository

To assist the integrated pharmacists to conduct the core roles, PSA Coordinators compiled a contemporary online repository of resources related to medicines use and management of chronic disease in Aboriginal and Torres Strait Islander peoples, taking into account jurisdiction-specific differences in legislation and best-practice guidelines.

This online repository was available to all participating integrated pharmacists via the Pharmacist Resources tab of the dedicated IPAC Project Pharmacists Training portal on the PSA website.

The resources compiled and collated could be broadly categorised as:

- References and evidence-based guidelines
- IPAC Project information sheet and consent form
- Clinical information systems
- IPAC Project core roles (training presentations, forms, useful website links)
- Pharmacists working with Aboriginal people
- Specific information relating to relevant disease states
- Other useful resources
- Legislation related to the practice of pharmacy

(For further details of repository content see Appendix A – IPAC Project Pharmacist Resources List).

Pharmacists were also encouraged by PSA Coordinators to explore the availability of additional professional references and resources provided by their state-based government health library. In Victoria, for example, pharmacists working within ACCHSs could access the Clinicians Health Channel and its significant drug information databases, journals and guidelines. Another source of locally-relevant treatment guidelines accessible by the pharmacists was HealthPathways, a web-based information portal supporting clinicians to plan patient care through primary, community and secondary health care systems.

2.4 Facilitated teleconferences

In acknowledging that the integrated pharmacists were predominantly working in professional isolation during the project, the PSA project coordinators established monthly teleconference meetings via Zoom once all integrated pharmacists had commenced work at their respective ACCHSs. These 1-hour meetings were held regularly throughout the implementation phase and enabled dissemination of project-related information, priorities and progressive data summaries, as well as providing opportunities for the integrated pharmacists to share their experiences and seek advice from their colleagues. Integrated pharmacists were invited to contribute agenda items for the meetings and to propose topics for open discussion at the end of each meeting.

To take into account the different days of the week routinely worked by the integrated pharmacists and to optimise participation, each monthly teleconference was initially conducted with the same agenda on two separate days. Over the course of the implementation phase, pharmacist turnover and reallocation of some FTE between ACCHSs allowed for single monthly meetings to capture the vast majority of participants.

The PSA Coordinators circulated a summary of key points to all integrated pharmacists soon after each monthly teleconference, noting that some integrated pharmacists were unable to join the teleconferences due to work commitments such as team meetings or patient appointments.

2.5 Discussion forum

Using the dedicated IPAC Project Pharmacists portal accessible online by the integrated pharmacists via the PSA website, the PSA Coordinators created an online discussion forum in the early months of the implementation phase. This forum enabled the PSA Coordinators and integrated pharmacists alike to both create and contribute to discussion topics of relevance to the project and/or the Aboriginal and Torres Strait Islander health sector. The NACCHO Coordinators were also granted access to the forum to provide input as they had significant experience as pharmacists working in the Aboriginal Health Service sector.

The layout and visibility of discrete topics, or 'threads', made it possible for integrated pharmacists to easily refer back to previous discussions and to review uploaded documents.

2.6 Social media

Following completion of induction training, the PSA project coordinators created a closed WhatsApp® group specifically for use by themselves, the NACCHO project coordinators and the integrated pharmacists throughout the IPAC Project. The intent of connecting the integrated pharmacists and project coordinators using a social media platform was to provide a means for timely communication of information when needed, to enable rapid feedback to be sought from colleagues in the event of urgent queries, and also to enable the planning and coordination of opportunities to come together (eg conferences, workshops) for networking purposes.

The PSA Coordinators served as administrators of the closed WhatsApp® group, with messages secured with end-to-end encryption and unable to be accessed by third parties.

2.7 Mentor support

During the establishment phase of the project, feedback was sought from pharmacist members of the PSA/NACCHO ACCHO Pharmacist Leadership Group as well as other experienced Aboriginal Health Services pharmacists to explore availability of potential mentors who could be matched with the integrated pharmacists. Significant experience also existed within the Project Team itself, which could be called upon by the integrated pharmacists when needed. While it was not a requirement for the project coordinators employed by PSA and NACCHO to be registered pharmacists, these four positions were ultimately all filled by pharmacists with extensive combined experience working with Aboriginal and Torres Strait Islander clients, conducting medication management reviews and undertaking review and implementation of program delivery to the AHS sector.

The primary aim of the mentoring program was to facilitate communication between the IPAC Project integrated pharmacists and experienced Aboriginal Health Service pharmacists to share their experiences and receive guidance in the early stages of working within an ACCHS.

3. Results

The platforms used to support integrated pharmacists during the IPAC Project were acceptable and effective across a wide range of healthcare settings. Integrated pharmacists' utilisation of the various means of support available differed according to personal preference and ease of access from their respective ACCHSs. The perceived value of the support from PSA Coordinators received by the integrated pharmacists was evidenced by means of feedback received by the project's Qualitative Evaluation Team. Details of integrated pharmacist feedback are included in the project's Qualitative Evaluation Report to the PSA. ³

An excerpt from the report stated;

“Another enabler for pharmacist integration was the support provided to them by the PSA Project Coordinators. Responses to the pharmacists' queries were valuable and timely and allowed the pharmacists to continue their work without delay. Pharmacists participated in a peer support network established by the PSA Project Coordinators using app technology, which enabled them to develop supportive relationships with other IPAC pharmacists in the same role”.

And a quote from an integrated pharmacist;

“Support and training from the PSA team was excellent. With provision of extensive resources, thorough training before the project started and facilitating networking with the other IPAC project pharmacists via the discussion forum, monthly conference calls and WhatsApp group, the PSA representatives gave me every opportunity to clarify, ask questions, seek guidance on any matter.” (Pharm15)³

Phone and email support

Regular communication by phone or email occurred between PSA Coordinators and integrated pharmacists. The integrated pharmacists contacted PSA Coordinators for support on at least a daily basis. For examples of clinical queries discussed, see Table 3.

Table 3 – Examples of clinical queries received by PSA Coordinators from integrated pharmacists

Queries received from IPAC integrated pharmacist	Support offered by PSA Coordinator(s)
Assistance sought for training opportunities to up-skill with respect to mental health & substance misuse issues in Aboriginal communities. This is a big focus at __ACCHS, where (the integrated pharmacist) has been asked to participate in Social & Emotional Wellbeing team...	Directed integrated pharmacist to several resources including GuildEd Harm Minimisation online course for pharmacists, & HealthInfoNet review-of-illicit-drug-use-among-aboriginal-and-torres-strait-islander-people. Also directed to (local) PHN & Health Pathways for locally-specific information. Explored option of Aboriginal Mental Health First Aid course provided by MHFA Australia however this is only run face-to-face in WA; a copy of their Problem Drug Use Guidelines was forwarded to pharmacist XX.
Some guidance needed with metformin doses in reduced renal function, different references give different information...	Reinforced Australian Medicines Handbook, Therapeutic Guidelines, AUS-DI as Australian best-practice references, as well as offering relevant information from current edition of Renal Drug Handbook
Relayed by integrated pharmacist from a GP... Can Bydureon be prescribed with insulin?	Although Bydureon is indicated for use with insulin, the PBS schedule does not currently subsidise this combination (despite Byetta/insulin currently subsidised).
Second opinion sought regarding a patient with diabetes & Chronic Kidney Disease stage 2 but normotensive & no history of microalbuminuria – to recommend an angiotensin converting enzyme inhibitor or not?? Guidelines differ...	Further guidance sought from experienced renal unit pharmacist working within same jurisdiction. Recommendation was to follow the KHA-CARI* guidelines, which would support the use of an angiotensin converting enzyme inhibitor in this situation... email & attached link to guidelines forwarded to integrated pharmacist
How can access be gained to Victorian Clinicians Health Channel?	Link to registration process emailed to all IPAC integrated pharmacists working in Victorian ACCHS
Request for resources related to weight management in Aboriginal patients	Directed integrated pharmacist to the National Guide 3 rd Ed (from page 18...), local Health Pathways & HealthInfoNet. Other feedback also coming via Discussion Forum from other pharmacists
Assistance sought with resources for up-skilling/training AHWs in the area of CKD	Links to Kidney Health Australia Indigenous Resources, National Guide 3 rd Edition, & Chronic Conditions Manual chapters on Chronic Kidney Disease sent to integrated pharmacist via email, also encouraged integrated pharmacist to explore HealthInfoNet resources

<p>Where to find latest asthma updates?</p>	<p>Referred integrated pharmacist to Asthma Handbook updates</p> <p>https://www.astmahandbook.org.au/figure/show/31</p> <p>Also sent link which may help with creating education sessions for AHWs</p> <p>https://www.astmahandbook.org.au/populations/indigenous-people/management</p>
<p>We had a discussion about PPIs today and one of the doctors said you can't take a PPI with thyroxine?</p> <p>How strong is the evidence?</p>	<p>It does not appear that proton pump inhibitors & thyroxine can't be used together, but rather that higher (perhaps about 35% higher) doses of thyroxine may be necessary for patients taking proton pump inhibitors in order to achieve target TSH levels as the proton pump inhibitor will affect gastric acidity & therefore dissolution of thyroxine tablets.</p> <p>article from the NEJM:</p> <p>https://www.jwatch.org/na36643/2014/12/24/proton-pump-inhibitors-inhibit-absorption-levothyroxine</p> <p>And it's supporting study:</p> <p><i>J Clin Endocrinol Metab</i> 2014 Dec; 99:4481. (http://dx.doi.org/10.1210/jc.2014-2684)</p> <p>This Medscape article suggests monitoring TSH when a PPI is introduced, with potential to need to increase thyroxine dose by about 35% over several months...</p> <p>https://www.medscape.com/viewarticle/742089</p> <p>Interestingly some small studies have failed to demonstrate a clinically-significant interaction:</p> <p>https://www.ncbi.nlm.nih.gov/pubmed/25372582</p>
<p>Information sought regarding studies &/or opinions around use of fenofibrate to reduce progression to diabetic retinopathy</p>	<p>Referred integrated pharmacist to the FIELD study, & ACCORD-eye study, also an article in AFP Volume 44, No 6 2015 pages 367-370 entitled: 'The use of fenofibrate in the management of patients with diabetic retinopathy: an evidence-based review'</p>
<p>Do you happen to know if there is a good guideline for managing blood pressure in renal patients – especially once on dialysis?</p>	<p>Referred integrated pharmacist to the Kidney Health Australia Caring for Australasians with Renal Impairment (KHA-CARI Guidelines at http://www.cari.org.au/ with direction to the Chronic Kidney Disease Guidelines tab up top...</p> <p>Also this article which may be of interest:</p> <p>https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4445132/</p> <p>Or RACGP Kidney Disease Management in General Practice:</p>

	<p>https://www.racgp.org.au/clinical-resources/clinical-guidelines/guidelines-by-topic/view-all-guidelines-by-topic/chronic-disease/chronic-kidney-disease-management noting this tends to refer back to the KHA-CARI Guidelines...</p>
<p>Another opinion sought please, on combined use of empagliflozin + exenatide? The PBS note is a little confusing...</p>	<p>Initial opinion sought from an IPAC integrated pharmacist who is also a CDE, her response: 'We do see these combinations quite often as their modes of action work very synergistically together. There is a TGA approval for this combination but no PBS reimbursement as of yet'.</p> <p>Further clarification sought via email from pbs@health.gov.au with response received:</p> <p>In all of the listings the note is consistent that use of exenatide in combination with SGLT2 inhibitor <u>is not PBS-subsidised</u>, whether dual or triple therapy. Further details regarding the PBS listing for exenatide can be found online at http://www.pbs.gov.au/medicine/item/10888C-3423E-3424F.</p>
<p>I am trying to find resources regarding keeping medication refrigerated - do you know of any posters, flyers, or lists of medications that need to be kept in the fridge, storage conditions and if it is a legal requirement or accreditation requirement?</p>	<p>See Therapeutic Goods Administration website re storage of refrigerated medicines, refer to section 8...</p> <p>https://www.tga.gov.au/publication/australian-code-good-wholesaling-practice-medicines-schedules-2-3-4-8#cold</p> <p>See also;</p> <p>https://www.safetyandquality.gov.au/standards/nsqhs-standards/medication-safety-standard/medication-management-processes/action-414</p> <p>The Strive for 5 guidelines have some good stickers & posters, but predominantly for vaccines...</p> <p>https://www.health.gov.au/resources/publications/national-vaccine-storage-guidelines-strive-for-5</p>

* KHA-CARI – Kidney Health Australia Caring for Australasians with Renal Impairment

Site visits by PSA Project Coordinators

A total of 20 site visits across 16 ACCHSs were conducted by PSA Project Coordinators during the intervention period, predominantly between February and June 2019. One participating site was not visited by a PSA Coordinator due to resignation of the integrated pharmacist and subsequent recruitment of an IPAC integrated pharmacist already working at another participating ACCHS to take over this role. Another site was visited by a NACCHO Coordinator in place of a PSA Coordinator as the timing of this visit coincided with a scheduled support visit by the NACCHO Coordinator. The time needed to plan, schedule and undertake these visits was considerable however the benefits were significant in terms of providing project support, enhancing personal communication and fostering a sense of teamwork between project coordinators and integrated pharmacists.

During site visits, advice on a range of topics was given to integrated pharmacists to assist with optimising project delivery, including;

- Consideration of different strategies to optimise patient referral and consent to participate in the project
- Revision of all core roles, tailored to local context and acknowledging priority areas identified in individual Pharmacist Activity Workplan
- Identification of where certain day to day activities 'fit' into each of the core roles and can therefore be captured in the logbook accordingly
- Thorough consideration of time taken to conduct core role activities (some pharmacists were inadvertently under-reporting this) to ensure accuracy of this data capture in the logbook

Informal feedback received by PSA Coordinators from the integrated pharmacists following site visits confirmed that the visits were helpful to clarify core role activities and requirements for data capture, and provided a welcome opportunity for face to face contact with the PSA Coordinators. Some pharmacists reported that the site visits would have been more beneficial if they had been conducted earlier in the implementation phase. Reflections and observations made during site visits prompted the addition of agenda items for discussion during pharmacists' monthly teleconferences to enable dissemination of project-related strategies found to be useful and successful by some integrated pharmacists.

Information gathered from the site visits was shared by the PSA Coordinators with the Project Team to enhance understanding of the early enablers and challenges experienced by the integrated pharmacists, and the associated impacts on project implementation. This also helped to identify areas of need for additional support from NACCHO Coordinators to encourage further engagement from ACCHSs.

Recognition of the significant time reported by integrated pharmacists to undertake participant recruitment, core role activities and data capture helped to inform Project Team decisions related to realistic adjustment of the target for consented patient numbers across the project.

Facilitated teleconferences

Throughout the implementation phase, a total of eleven monthly teleconferences were held. Each meeting was facilitated by a PSA Coordinator and began with an Acknowledgement of Country, followed by an update on project progress related to issues such as participant consent numbers, data totals and targets, site visits and timelines. Agenda items for discussion during the monthly meetings were diverse in nature as shown in Table 4.

Table 4 - IPAC Project monthly teleconference topics

Project-specific topics	General topics
Local cultural induction – has it taken place?	HMR's – Medicare vs 6CPA rules and tracking claims data
Patient recruitment – challenges, successes & strategies to assist	Patient medicine lists
Consent – challenges, successes & strategies to assist	Medication review reports – ways to communicate with the GP
Mentoring Program – Update, frequency & methods of contact	MBS items – where can/does the pharmacist fit? Workflow processes to include pharmacist.
Promotional Materials – brochures & video	Upcoming pharmacy conferences and therapeutic updates for consideration
MAI/AOU* - targets & timelines	Impact of Health Care Homes Trial
Drug Use Evaluation – further discussion, sharing ideas	NAIDOC week – get involved
N-MARS** (Q1a consistency, who can conduct survey, who can enter keyword in CIS)	Best Practice software – tips & tricks
Case studies & patient testimonials - share	Aged Care packages – what is funded?
Recalling patients – how/when? Challenges & successes, project timelines	Biometric measures in Communicare & Best Practice
Stakeholder Liaison Plans - progress	HMRs – aim for progression to item 900 claims
JCU Qualitative Evaluation - scheduling	
Transitional Care – Pathology	
Logbook reports vs CC/BP list of JCU Consented patients – ensure these align	
Deceased patients – what to do?	
MAI reliability testing – intra/inter pharmacist	
N-MARS... repeat survey % progress	
JCU Consent Audits	

*MAI/AOU = Medication Appropriateness Index/Assessment of Underutilisation

**N-MARS = NACCHO Medication Adherence Readiness Scale

Discussion forum

Throughout the intervention phase, a total of 91 unique conversation threads were posted to the discussion forum, with 192 replies from integrated pharmacists and/or project coordinators. The nature of conversation threads could broadly be categorised as clinical, CIS, programs/services and project-specific. For examples see Table 5.

Table 5 - Discussion Forum (examples of topics)

General topic groups	Examples
Clinical updates and sharing of clinical resources of relevance	'Clinical yarning' article, azithromycin for bronchiectasis, cultural responsiveness framework, heart failure and fluid restrictions, duration of dual antiplatelet therapy for patients with non-ST elevation myocardial infarction, magnesium supplementation, antimicrobial stewardship programs, dose schedule of metformin/glibenclamide to optimise adherence, liquid iron shortage, suggestions for diabetes patient group education, Heart Foundation Booklet - Living well with Heart failure for Aboriginal and Torres Strait islander patients, puffer posters, B.Strong brief intervention training (Qld), 'Kidney Stories' resource available online, Indigenous Australian Dietary Guidelines (poster), use of renal prescribing guidelines, palatability of statins, 1-page diabetes medicines table, evidence for aspirin for prevention of bowel cancer
Clinical information systems	HMR editable template for Communicare, access to medication lists in Best Practice software, creating medication list templates
Programs and services	PPI changes to PBS, extemporaneous PBS scripts, Home Care packages, summary able of MBS potential pharmacist involvement, NACCHO HMR promotional poster for Aboriginal clients, NACCHO QUMAX flexible funding agreements, SafeScript (Vic)
Project-related matters	IPAC Project promotional materials, training presentations, updated participant briefs & core role assessment forms, revised consent forms, DUE examples, patient recalls and reminders, key points from monthly teleconferences, health worker education, tips for patient follow-up

Social media

In addition to the PSA and NACCHO project coordinators, a total of 18 integrated pharmacists accepted the invitation to join the IPAC Project Pharmacists' WhatsApp® group. A small proportion of pharmacists declined the invitation to join the social media group, having a personal preference for the other support options available within the project.

Throughout the implementation phase, members of the group posted 530 messages (including 45 photos, 14 website links and 2 documents), representing an average of 33 messages per month.

Conversation topics were again diverse and while initially intended to promote interpersonal connection between the integrated pharmacists, over time these were more likely to involve requests for timely feedback from colleagues to assist with current clinical issues of priority. Ease of access to the app via a mobile device, along with its responsiveness, were viewed by the integrated pharmacists as both convenient and very helpful when conducting their project activities.

Mentor support

The existence of significant expertise within the Project Team was acknowledged as the predominant source of informal mentor support available to the integrated pharmacists throughout the implementation phase. This was evidenced by significant and consistent utilisation of the various means by which the integrated pharmacists could communicate with the Project Team, including contact by phone or email, participation in monthly teleconference meetings, and use of the discussion forum and closed social media group.

While the intention was that each integrated pharmacist would be matched with an experienced mentor, in reality there were less mentors available than integrated pharmacists (mentees). As a proportion of the integrated pharmacists already had considerable experience working with Aboriginal or Torres Strait Islander clients, the PSA Coordinators liaised with each integrated pharmacist individually to ascertain whether they felt that they would benefit from the support of a mentor.

A number of the integrated pharmacists with significant prior experience in the AHS sector themselves expressed a willingness to support other integrated pharmacists with less experience. From these discussions, PSA and NACCHO Coordinators conducted preliminary matching of mentors with mentees, taking into account similarities in rurality of workplace.

Within the group of 24 pharmacists initially trained to participate in the project, preferences for mentor support were variable, as shown in Table 6.

Table 6 - IPAC Project mentor allocation summary

Pharmacists with formal PSA Mentor Program agreement	Pharmacists with informal (ad-hoc) mentor arrangement	Pharmacists who declined the offer of a mentor
11	3	10

Eleven pharmacists accepted formal mentor matching and proceeded to register and engage with PSA's Mentoring Program. This included mentee access to the Mentoring Education and Resources Hub (MERHub), an online portal of videos, e-Learning modules, fact sheets, conversation maps, tools and templates.

The mentors allocated to these pharmacists were similarly granted mentor access to the MERHub. . The mentoring program was designed to deliver 3-4 scheduled meetings of about 1 hour duration over a 6-month period.

A further three pharmacists preferred to be able to contact a mentor infrequently, on an informal or ad-hoc basis.

The remaining ten pharmacists declined the offer of support from a mentor, predominantly due to prior experience working with Aboriginal or Torres Strait Islander people, but also citing reasons such as:

- They were happy with availability and expertise of the Project Team members for support
- They were content with the proposed project support structure of monthly teleconferences, online discussion group and WhatsApp® social media connection
- They had another IPAC Project integrated pharmacist at the same ACCHS available to 'bounce ideas off'

All integrated pharmacists who accepted the offer of formal mentor support via PSA's Mentoring Program were invited to provide feedback on their experience. Of the eleven mentees registered with the program, 45% (n=5) provided feedback, which is routinely sought as a component of the PSA Mentoring Program at the end of the 6 month mentor/mentee agreement. Table 7 summarises all responses to selected survey questions.

Table 7 - Summary of PSA Mentoring Program mentee survey responses

Survey question	Responses	Additional comments
In my experience as a mentee I learnt:	Better communication skills	Knowledge about this area of pharmacy that I'm working in.
	More about how other people think	
	Important aspects of the pharmacy profession	
I will be able to use the learnings in my professional career:	Agree (60% of respondents)	Having someone to bounce ideas off made all the difference
	Strongly agree (40%)	
The mentoring timeframe was appropriate:	Agree (80%)	
	Strongly agree (20%)	
I will continue the relationship with my mentor:	Yes (80%)	
	No (20%)	
Our mentoring partnership worked well:	Agree (40%)	1. It is hard to fit scheduled meetings into our respective schedules, but the email communication worked well.
	Strongly agree (40%)	

	Disagree (20%)	2. It was good to have the prompt at 2 months to check we were on the right track. Maybe another prompt at 4 months would be good?
		3. I didn't need to use the program much. Regular check in's by mentor may be an idea.

4. Discussion

Throughout the IPAC Project implementation phase, support was provided to the integrated pharmacists through various means, including (but not limited to) phone and email support by PSA Coordinators and the wider Project Team, site visits by PSA Coordinators, mentoring, access to an online repository of relevant resources, regular monthly teleconferences, access to an online discussion group and contact by closed-group social media.

While a proportion of this support related to project-specific matters, many queries and discussions were related to clinical issues, clinical information systems, programs and services relevant to the health of Aboriginal and Torres Strait Islander clients attending ACCHSs. Utilisation of the various platforms of support on offer was significant and consistent across the implementation phase, with some differences in the use of individual support measures observed between integrated pharmacists according to personal preference and ease of access.

At the conclusion of the implementation phase of the project, a workshop was scheduled by the PSA Coordinators in lieu of final site visits to participating ACCHSs. The workshop was held in Darwin, facilitated by the PSA Coordinators, and attended by the majority of integrated pharmacists as well as all members of the Project Operational Team. A small proportion of integrated pharmacists were unable to attend due to personal or annual leave arrangements. The aim of the workshop was to explore the many enablers and challenges experienced by the integrated pharmacists throughout the project, with discussions taking place in a group setting to encourage reflection and conversations between attendees. The feedback received from integrated pharmacists during the workshop highlighted the 'positive project culture' and support received from PSA (and availability of support from NACCHO and JCU) as significant enablers throughout the project. Furthermore the integrated pharmacists strongly valued the opportunity to collaborate in the workshop setting itself, stating that this added to their feelings of connectedness to other pharmacists who shared a passion for working in the Aboriginal Health Service sector.

Pharmacists reported that being able to communicate easily with their Coordinators and peers via either the PSA IPAC Discussion Forum or the less formal social media WhatsApp® closed group was invaluable as they could seek and/or share information from other integrated pharmacists in a timely manner. The availability of project-related training material, resources and references on the PSA IPAC Training portal was also found to be particularly useful.

The portal enabled pharmacists to double check project processes, explore links to websites and resources relevant to Aboriginal and Torres Strait Islander health, and acted as a central repository for forms related to consent, adherence assessments and medicines appropriateness index audit surveys.

Having regular monthly teleconference meetings, facilitated by PSA Coordinators to encourage a support network / community of practice and update the integrated pharmacists, helped with understanding of the successes and challenges experienced across the participating project sites, with integrated pharmacists adding that this also made them feel less 'isolated' as new health professionals in their respective health services.

Inclusion of a substantial program of support incorporating multi-modal strategies as demonstrated in the IPAC Project must be considered essential when planning broader expansion of integrated pharmacist services to ACCHSs across Australia in the future.

Support measures for the implementation of medicines-related programs have been considered and funded in the past, with one example being the Medication Management Review Facilitator Program accompanying implementation of the Home Medicines Review Program almost 20 years ago.

An evaluation of the MMR Program validated the effectiveness of the facilitator role in increasing program uptake.⁴ This facilitator program had similarities to some earlier programs which involved employment of specialist resource staff to support particular initiatives in health care such as the National Prescribing Service (NPS) Facilitators and Enhanced Primary Care (EPC) Facilitators.

5. Conclusion

Substantive and considered program support for pharmacists integrated within ACCHSs is essential to enable effective delivery of medicines-related services through a coordinated and collaborative approach to improve the quality of care received by Aboriginal and Torres Strait Islander patients. Indeed there is a risk that integrating pharmacists into ACCHSs without adequate support may limit the uptake and effectiveness of an integrated pharmacist program.

Given the geographic spread of ACCHSs around Australia and the relative novelty of the integrated pharmacist role, it is expected that effective support will be required for integrated pharmacists to adapt to new healthcare activities and workflow and to overcome feelings of professional isolation.

Support for integrated pharmacists may be provided by various means as demonstrated in the IPAC Project, and should be multi-modal to take into account accessibility, ease of utilisation and responsiveness. Beyond the IPAC Project, provision of adequate training and support, along with the creation of a community of integrated for pharmacists working with Aboriginal and Torres Strait Islander peoples, will enable sharing of sector knowledge and expertise with the aim of increased uptake, up-skilling and retention of pharmacists working in the ACCHS sector.

6. Recommendations

<p>1/ Establish a program to provide ongoing support to integrated pharmacists working (or intending to work) in the ACCHS sector</p>	<p>Pharmacist ACCHS Support Program role will:</p> <p>1.1 Facilitate access to training pathways for pharmacists commencing work within ACCHS.</p> <p>1.2 Provide a clinical mentoring service.</p> <p>1.3 Coordinate a mentoring program for pharmacists commencing working in the AHS sector to connect with pharmacists with prior experience.</p> <p>1.4 Maintain a contemporary online repository of resources related to medicines use and management of chronic disease in Aboriginal and Torres Strait Islander peoples.</p> <p>1.5 Coordinate a “community of practice” utilising a range of tools to connect pharmacists in the AHS sector eg facilitated online discussion forum, social media, gathering at forums</p>	<ul style="list-style-type: none"> • Enhanced support for pharmacists working (or intending to work) in the ACCHS sector, with resultant increase in available workforce of AHS pharmacists • Increased access to integrated pharmacist services by Aboriginal and Torres Strait Islander peoples with chronic disease • Increased retention of integrated pharmacists due to reduced feelings of professional isolation in the ACCHS workplace • Enhanced sharing of professional expertise between AHS pharmacists, with resultant up-skilling of integrated pharmacists working in the ACCHS sector
<p>2/ Promote availability of relevant continuing professional development (CPD) for pharmacists working in the ACCHS sector</p>	<p>2.1 Provision of accredited CPD activities related to Aboriginal and Torres Strait Islander health care, for inclusion in pharmacists’ annual CPD plans</p>	<ul style="list-style-type: none"> • Continuous improvement in the quality of care provided by pharmacists to Aboriginal and Torres Strait Islander Australians.

References

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2. Tan E, S. K. (2014). Integration of pharmacists into general practice clinics in Australia: the views of general practitioners and pharmacists. *Int J Pharm Pract*, 22(1), 28-37.
3. Preston R, Smith D, Drovandi A, Morris L, Page P, Swain L, Couzos S. Integrating Pharmacists within Aboriginal Community Controlled Health Services (ACCHSs) to improve Chronic Disease Management (IPAC) Project: Draft Qualitative Evaluation Report to the PSA. February 2020.
4. Urbis. Evaluation of the Home Medicines Review Program – Pharmacy Component. FINAL REPORT. Prepared for the Pharmacy Guild of Australia 2005.

Appendix

Appendix A – IPAC Project Pharmacist Resources List

IPAC Project Pharmacist Resources List

EVIDENCE BASED GUIDELINES

- National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people – ‘The National Guide’
<https://www.racgp.org.au/download/Documents/Guidelines/National-guide-3rd-ed.pdf>
- Remote Primary Health Care Manuals (including CARPA Standard Treatment Manual)
<https://www.remotephcmmanuals.com.au/home.html>
- Remote Health Atlas (Northern Territory)
<https://health.nt.gov.au/professionals/remote-health-atlas>
- NT Immunisation Schedule 2018 (adult)
<https://nt.gov.au/wellbeing/healthy-living/immunisation/adult-vaccinations>
- Primary Clinical Care Manual 9th Ed (Queensland Government)
<https://publications.qld.gov.au/dataset/primary-clinical-care-manual-9th-edition/resource/06f04fcb-6eb6-45eb-9770-c4a79a715b62>
- Chronic Conditions Manual 1st Ed 2015 (Queensland Government)
<https://publications.qld.gov.au/dataset/chronic-conditions-manual>
- The Australian Immunisation Handbook 10th Ed
<http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook10-home>

IPAC PROJECT CONSENT

Individual patient consent for participation in IPAC project:

- Master Participant Consent form for IPAC (Vic & Qld sites)
- Master Participant Information brief for IPAC (Vic & Qld sites)
- Master NT Top End Participant Consent form for IPAC Project
- Master NT Top End Participant Information brief for IPAC Project
- Master NT CA Participant Brief for IPAC Project
- Master NT CA Consent form for IPAC Project

GP consent for participation in the IPAC project (for qualitative analysis only)

- Master Vic GP Participation brief (Vic & Qld sites)
- Master Vic GP Consent form for IPAC (Vic & Qld sites)
- Master NT Top End Participant Consent form for IPAC Project
- Master NT Top End Consent form for IPAC Project
- Master NT CA GP Participation brief (for NT sites)
- Master NT CA GP Consent form for IPAC (For NT sites)

CLINICAL INFORMATION SYSTEMS

- Communicare - IPAC Procedures
- Best Practice - IPAC Procedures
- Best Practice training webinar (link)
- My Health Record PSA Guidelines for Pharmacists
<http://www.psa.org.au/wp-content/uploads/My-Health-Record-Guidelines-for-Pharmacists.pdf>

CORE ROLES

Core role 1 – Medication Management Reviews

- PSA Guidelines for pharmacists providing Home Medicines Review (HMR) services
- HMR flowchart
- Non-HMR criteria

Core role 2 – Team Based Collaboration

- Australian Cardiovascular Risk charts 2018
- MBS Fact Sheet
- MBS flowchart for Chronic Disease - Aboriginal and Torres Strait Islander Health Check (715)

Core role 3 – Medication Adherence Assessment and Support

- N-MARS Patient Survey form

Core role 4 – Medication Appropriateness Audit (MAI & AOU)

- MAI Patient Survey form
- MAI examples
- AOU Patient Survey form
- Therapeutic Guidelines – Suggested approach for glycaemic management in adults with Type 2 diabetes (algorithm)
- NT pneumococcal vaccination & re-vaccination schedule 2018

Core role 5 – Preventive Health care

- The National Guide Lifecycle Chart - Adult
<https://www.racgp.org.au/download/Documents/Guidelines/Adult-chart-National-guide-3rd-web-final.pdf>
- RACGP 'Red book' – Guidelines for preventive activities in general practice 9th ed
<https://www.racgp.org.au/your-practice/guidelines/redbook/>
- Australian Cardiovascular Risk charts 2018
- RACGP SNAP Guide
<https://www.racgp.org.au/your-practice/guidelines/snap/>

Core role 6 – Drug Utilisation Review

- DUR report template

Core role 7 – Education and Training

- How to make an oral case presentation to healthcare colleagues
<https://www.pharmaceutical-journal.com/learning/learning-article/how-to-make-an-oral-case-presentation-to-healthcare-colleagues/20200876.article>
- IPAC Project Education Session Evaluation form
- IPAC Project Education Session Evaluation Summary Report

Core role 8 – Medicines Information Service

- SHPA Medicines Information Services
<https://www.shpa.org.au/medicines-information-services>
- PBS Schedule
<http://www.pbs.gov.au/pbs/home;jsessionid=11z8y3hxiba5q14bw10g4gbf2e>

Core role 9 – Medicines Stakeholder Liaison

- Medicines Stakeholder Liaison – Purpose of Plan
- Medicines Stakeholder Liaison - Plan and Outcomes

Core role 10 – Transitional Care

- NPS learning module ‘Get it Right – Taking a Best Possible Medication History’
<https://learn.nps.org.au/mod/page/view.php?id=5436>

DISEASE STATE SPECIFIC INFORMATION

- Australian Indigenous HealthInfoNet
<https://healthinonet.ecu.edu.au/>
- Kidney Health Australia – Indigenous Resources
<http://kidney.org.au/your-kidneys/support/indigenous-resources>
- Kidney Health Australia – Caring for Australasians with Renal Impairment (KHA-CARI) Guidelines
<http://www.cari.org.au/>
- Kidney Health Australia - Chronic Kidney Disease Management Handbook
<http://kidney.org.au/health-professionals/prevent/chronic-kidney-disease-management-handbook>
- Kidney Health Australia – download free smartphone app CKD GO!
- Diabetes Australia – Aboriginal and Torres Strait Islander people
<https://www.diabetesaustralia.com.au/aboriginal-and-torres-strait-islanders>
- Stroke Foundation
<https://strokefoundation.org.au/>
- The Heart Foundation – Aboriginal Health Resources for Health Professionals
<https://www.heartfoundation.org.au/for-professionals/aboriginal-health-resources>

- Lung Foundation Australia – Indigenous Support
<https://lungfoundation.com.au/patient-support/indigenous/>
- National Asthma Council Australia - Asthma in Aboriginal and Torres Strait Islander peoples <http://www.astmahandbook.org.au/populations/atsi-peoples>

OTHER USEFUL RESOURCES

- PSA Career Pathway – Aboriginal and Torres Strait Islander Health Services Pharmacist
<http://www.psa.org.au/my-career-and-cpd-plans/career-pathways/aboriginal-health-pharmacist>
- Aboriginal Interpreter Service available for the NT
<https://nt.gov.au/community/interpreting-and-translating-services/aboriginal-interpreter-service>
- National Translating and Interpreting Service (TIS) - free for doctors and health services:
<https://www.tisnational.gov.au>
- Aboriginal and Torres Strait Islander Health Performance Framework 2017 Report
<https://www.pmc.gov.au/sites/default/files/publications/indigenous/hpf-2017/tier3/315.html>

LEGISLATION - practice of pharmacy

- Victoria
<http://www.psa.org.au/practice-support-and-tools/psa-information-framework/legislation-victoria>
- Northern Territory
<http://www.psa.org.au/practice-support-and-tools/psa-information-framework/legislation-northern%20territory>
- Queensland
<http://www.psa.org.au/practice-support-and-tools/psa-information-framework/legislation-queensland>
- Pharmacy Board of Australia Guidelines
<http://www.pharmacyboard.gov.au/Codes-Guidelines.aspx>
- Professional practice standards and guidelines published by the Pharmaceutical Society of Australia (PSA)
<http://www.psa.org.au/wp-content/uploads/Professional-Practice-Standards-V5-PDF-5.5mb.pdf>

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