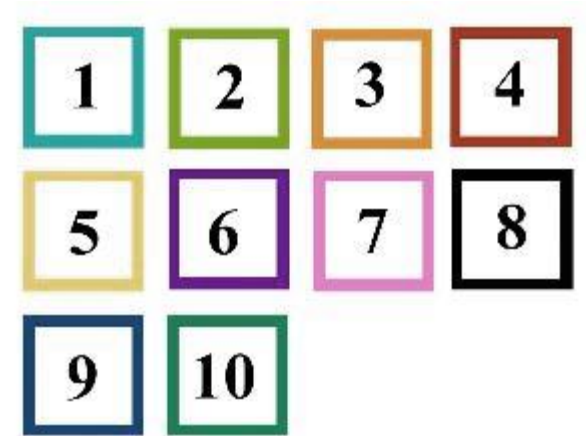


Integrating Pharmacists within Aboriginal Community Controlled Health Services to improve Chronic Disease Management (IPAC) Core role 4 Assessment of Underutilisation (AOU)

- Prompts identification of medicines that have been omitted
- Conducted by the practice pharmacist at the time of MAI audit
- Conducted at 2 points in time, once at baseline (month 1-3) & again 12 months later
- Also applied for each HMR or non-HMR conducted by the practice pharmacist



- 10 evidence-based indicators
- Drawn from current recommendations within Australian best practice prescribing guidelines
- Pharmacist needs to be aware of the clinical condition of the participant, their medications & medication history
- Clinical judgement needed to identify other prescribing omissions



- Consider whether prescribing has been adjusted to take into account clinical appropriateness, contraindications or clinical decisions to withdraw therapy
- Ratings dichotomized as ‘no prescribing omission’ or ‘omission of an indicated drug’
- The participant does not need to be present
- Logbook enables AOU outcome to be recorded at the end of each MAI assessment
- Logbook also facilitates recording of the AOU for every HMR & Non-HMR

Patient group

- A patient with calculated high absolute risk for CVD (>15%)

Core recommendation 1

- If high risk (calculated >15%): the patient should be prescribed both BP and lipid lowering therapy

(Ref: NVDPA Guidelines for the management
of absolute cardiovascular disease risk. 2012)



- A prescribing omission will be determined if there is an absence of BP or lipid lowering therapy in a patient who is of calculated high absolute CV risk
- Record details of the prescribing omission in the logbook (4 options)

Patient group

- A patient in a clinically high-risk category for CVD (>15% risk)

Core recommendation 2

- If high risk (clinically determined): the patient should be prescribed both BP and lipid lowering therapy

(Ref: NVDPA Guidelines for the management
of absolute cardiovascular disease risk. 2012)



A patient is known to be at clinically high risk (>15%) for CVD in the following circumstances

- Diabetes and age >60 years
- Diabetes with microalbuminuria
- Moderate or severe CKD (persistent proteinuria or estimated glomerular filtration rate (eGFR) <45 mL/min/1.73 m²)
- A previous diagnosis of familial hypercholesterolaemia
- SBP ≥180 mmHg or DBP ≥110 mmHg
- Serum total cholesterol >7.5 mmol/L
- Aboriginal and Torres Strait Islander adults aged over 74

- A prescribing omission will be determined if there is an absence of BP or lipid lowering therapy in a patient who is of clinically high absolute CV risk
- Record details of the prescribing omission in the logbook (4 options)



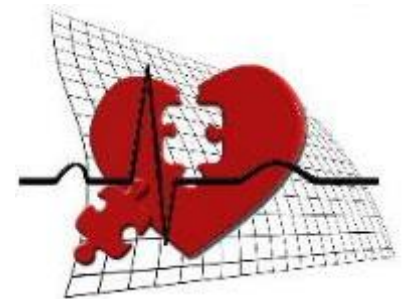
Patient group

- A patient with an established diagnosis of cardiovascular disease

Core recommendation 3

- The patient should be commenced on low-dose aspirin treatment (75-150mg) unless contraindicated. Consider alternative antiplatelet agents such as clopidogrel (75 mg) if aspirin hypersensitivity is present

(Ref: National Guide, 3rd ed. 2018,
& eTG – Cardiovascular 2018)



- A prescribing omission will be determined if there is an absence of low-dose aspirin or clopidogrel therapy in a patient with established cardiovascular disease
- Record details of the prescribing omission in the logbook (3 options)

A patient with Type 2 diabetes and microalbuminuria or macroalbuminuria

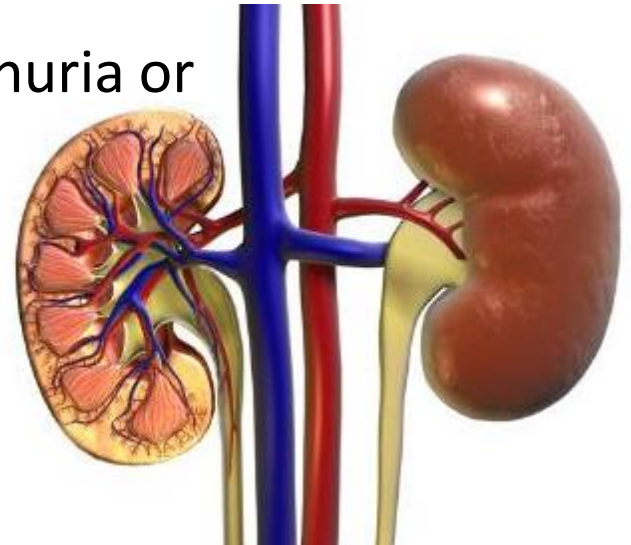
Patient group

- A patient with Type 2 diabetes and microalbuminuria or macroalbuminuria

Core recommendation 4

- In people with T2DM and microalbuminuria or macroalbuminuria, an ACEI or ARB should be used to protect against progression of kidney disease

(Ref: General Practice Management of Type 2 Diabetes, RACGP, 2016-18, 10.4 Nephropathy & Australian Medicines Handbook, Jan 2018)



Interpreting Albumin to Creatinine Ratio (ACR)

	Gender	Normal albumin excretion	Microalbuminuria	Macroalbuminuria
Urinary albumin to creatinine ratio	Male	<2.5mg/mmol	2.5-25mg/mmol	>25mg/mmol
	Female	<3.5mg/mmol	3.5-35mg/mmol	>35mg/mmol

- A prescribing omission will be determined if there is an absence of treatment with ACEI/ARB in a patient with T2DM with microalbuminuria or macroalbuminuria
- Record details of the prescribing omission in the logbook (3 options)

Patient group

- A patient without diabetes who has CKD and macroalbuminuria

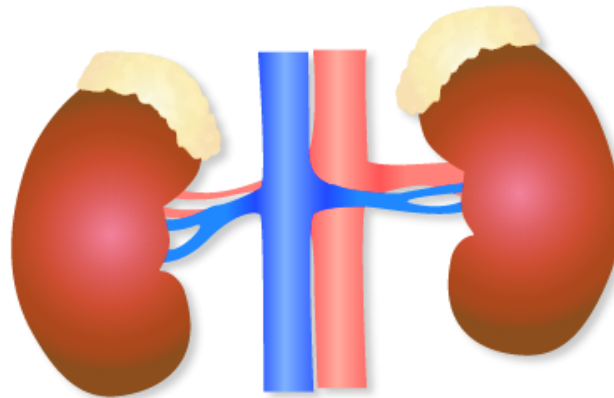
Core recommendation 5

- In adults without diabetes who have CKD and macroalbuminuria, advise treatment with an ACEI or ARB regardless of eGFR or BP level

(Ref: KHA-CARI Guidelines May 2013, &
National Guide 3rd ed. 2018, p97)



- A prescribing omission will be determined if there is an absence of treatment with ACEI/ARB in a patient without diabetes who has CKD and macroalbuminuria
- Record details of the prescribing omission in the logbook (3 options)



A patient with heart failure with a reduced left ventricular ejection fraction (HFrEF)

Patient group

- A patient with heart failure with a reduced left ventricular ejection fraction (HFrEF)

Core recommendation 6

- An ACE inhibitor or ARB is recommended in all patients with HFrEF unless contraindicated or not tolerated...to decrease mortality and decrease hospitalisation

(Ref: National Heart Foundation of Australia (NHFA) and the Cardiac Society of Australia and New Zealand (CSANZ) 2018, p 22 and p 26. Also eTG Cardiovascular, March 2018)

- A prescribing omission will be determined if there is an absence of treatment with ACEI/ARB in a patient with HFrEF
- Record details of the prescribing omission in the logbook (3 options)



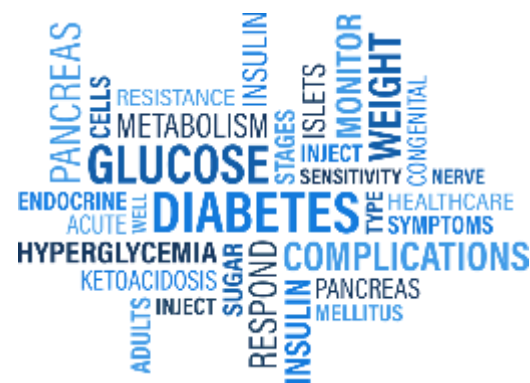
Patient group

- A patient with T2DM who needs metformin

Core recommendation 7

- Metformin is the first-choice antihyperglycaemic drug in T2DM

(Ref: eTG Endocrinology, March 2018)



- A prescribing omission will be determined if there is an absence of treatment with metformin in a patient with T2DM, where there is no contraindication or intolerance to metformin
- Record details of the prescribing omission in the logbook (1 option only)

A patient with T2DM who needs a second oral antihyperglycaemic drug

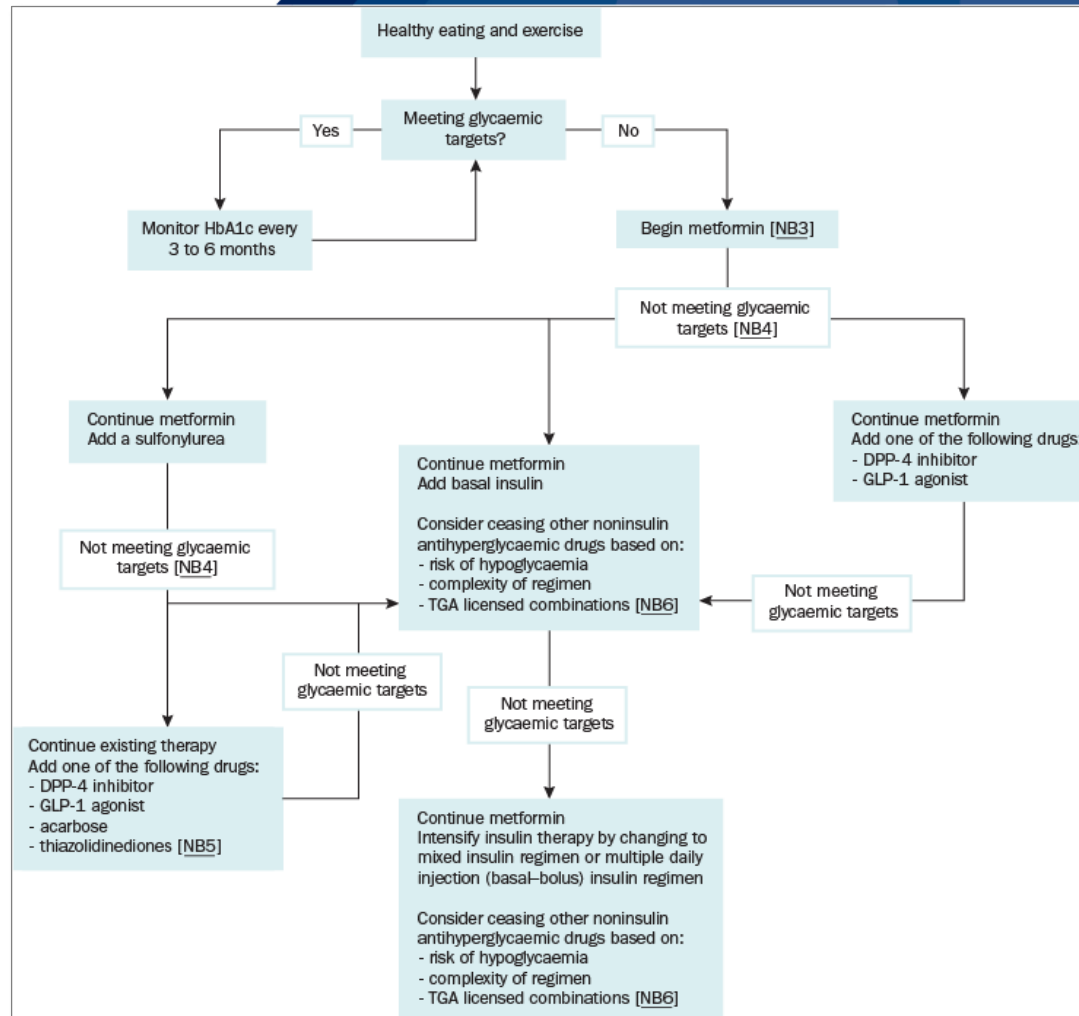
Patient group

- A patient with T2DM who needs a second oral antihyperglycaemic drug

Core recommendation 8

- If glycaemic targets are not met with lifestyle measures and the maximum tolerated dose of metformin, the next step is to add a second antihyperglycaemic drug
(Ref: eTG Endocrinology March 2018)
- If omission determined, record details of the prescribing omission in the logbook (4 options)

Glycaemic management in adults with Type 2 diabetes



Patient group

- People for whom 23vPPV vaccine is indicated

Core recommendation 9

- Recommend 23vPPV in those aged 15-49 years with underlying conditions (chronic cardiac and lung disease, chronic liver disease, diabetes, alcoholism & tobacco smokers) increasing the risk of invasive pneumococcal disease, and all patients >50 years

(Ref: National Immunisation Handbook, 10th ed)

- A prescribing omission will be determined if the patient is overdue for 23vPPV at age 15-49 or from age 50
- Record details of the prescribing omission in the logbook (5 options)



Patient group

- People with Acute Rheumatic Fever (ARF) or Rheumatic Heart Disease (RHD)

Core recommendation 10

- Recommend long-term prophylactic antibiotics (either benzathine penicillin every 21-28 days, or the less preferred option of daily oral penicillin V) for the prevention of recurrent rheumatic fever attacks

(Ref: National Guide, 3rd Ed. 2018)

- ‘Long-term’ will be defined as treatment duration of at least 10 years



- A prescribing omission will be determined if there is an absence of chemoprophylaxis management in a patient with ARF/RHD, or an absence of treatment with penicillin with no evidence of penicillin allergy, who still requires chemoprophylaxis. The chemoprophylaxis may be for a period of 10 years or more.
- Record details of the prescribing omission in the logbook (3 options)



- Was there a prescribing omission for this patient?
- If omission of an indicated drug was identified, what type of medicine was omitted?
- Which of the core items in the 'prescribing omission checklist' does this omissions relate to?
- Is there another omission you want to enter?
- If there is another omission, for which of the following conditions does the omission apply?
- What reference was used to identify this prescribing omission?

- A flagged entry in the ACCHS CIS is not required
- Communicate the findings of the AOU to the prescribing team



Thank you!