Central Hume Primary Care Partnership Pharmacy Project – Interim Report Stage One May & June 2018

Background

One in two Australians now have a chronic disease and one in four have at least two chronic health diseases.

In Central Hume: diabetes, heart disease, and respiratory conditions (COPD – Chronic Obstructive Pulmonary Disease and Asthma) are the high prevalence diseases.

Local community pharmacies and pharmacists are the first point of call for clients, the health professional who sees clients most frequently (at least once a month to fill prescriptions for regular medications) and are a free consultation service. Pharmacists can contribute to monitoring of clients in between GP and specialist appointments, and should be seen as part of the whole primary health care team.

There is anecdotal evidence that service providers and communities in the Central Hume catchment, under-utilise pharmacies in primary health care, particularly in relation to chronic conditions due to a poor awareness of their role and scope of practice.

Purpose

This project seeks to connect the sixteen (16) local community pharmacies in Central Hume (Alpine, Benalla, Mansfield and Wangaratta Local Government Areas) to Alpine Health, Benalla Health, Mansfield District Hospital, Northeast Health Wangaratta and Gateway Health Wangaratta.

The purpose of making these connections is to enhance information access between services and the community by strengthening integration, and improving communication among providers.

Expected outcomes:

- Recognition of the role of pharmacies in providing education and support that assists people to self-manage their chronic condition(s)
- Pharmacies are recognised and utilised as part of the health system through strengthening service integration and improved communications
- Improving the self-management capability/capacity of people living with chronic conditions through targeted and appropriate support from pharmacies

The Victorian Department of Health and Human Services (DHHS) Ovens Murray Goulburn (OMG) East Division has funded this project under the OMG Chronic Care Strategy.

Objectives

The project objectives are:

- Partnering with local community pharmacies to enhance the self-management capability of people living with chronic conditions using health literacy principles. These include communication and understanding at point of contact; easy access to health information, support groups and services; with information available in various formats.

- Facilitate the implementation of local care pathways for people living with chronic conditions using evidence based guidelines.

Methodology

The methodology included:

1. An initial phone conversation with the head or senior pharmacist at each local community pharmacy, explaining the project and arranging a visit time to discuss.
2. Made face to face visits to each local community pharmacy in Central Hume to provide an information pack about the project, explore opportunities and knowledge transfer requirements via discussion and a follow-up survey. The survey was administered utilising various methods (paper/hard copy and prepaid envelope, survey on iPad, survey link sent via email).
3. Collating survey findings and using these to inform project objectives and formulate recommendations for future work.

Key Findings

The pharmacists' feedback from the face to face visits is outlined below:

Systems Integration –

- Little knowledge of what services are available and offered in the local areas
- Hard/difficult for GPs and other health professionals to recognise/acknowledge the work and capacity of pharmacists (value/perception of pharmacists role)
- GPs not taking advice/suggestions for medication adjustments even when it is coming from clients
- Perception that pharmacists only call to "fix mistakes"
- A face to face approach was highly valued by the pharmacies and is much better for responses (14 out of 16 pharmacies visited spent time with the project officer to discuss the project and answer questions – ranging from 15 minutes to 1.5 hours)
- Knowledge transfer of information of where to go to and who to contact
- All pharmacies agreed with high prevalence conditions and predicted local statistics to be higher

Person Centred Care –

- Free consultation service and seeing clients more often than other health professionals (at least once a month to fill prescriptions)
- Pharmacotherapy and compounding offered at some pharmacies
- Focus on mental health and pain management as they are key factors in chronic disease
- Concern at larger pharmacies that consumer perceptions are that pharmacists are "too busy/lack time" to speak with them about medications or provide advice

Barriers –

- Lack of role clarity (pharmacists, GPs)
- GPs are not valuing pharmacists' expertise and role in Chronic Disease Management, and the perception is that pharmacists are taking over
- Smaller 'one pharmacist' pharmacies have limited availability and time constraints (shorter time to spend with each patient)
- On the spot encounters and discussions about medications are difficult for smaller 'one pharmacist' pharmacies due to time constraints, and asking clients to return for these discussions creates the perception of a formal appointment, where the client is often anxious and does not return
- Current funding model for pharmacies is challenging (infrastructure – appropriate areas/rooms and untrained staff)
- Chronic disease knowledge is not consistent throughout the Central Hume catchment across pharmacists, GPs and other health professionals, some may have outdated practices and unsure of current best practice methods
- Knowledge is not up to date and difficult/hard to monitor the knowledge level of other pharmacists
- Each pharmacy identified various aspects that could be improved in the future, so future planning needs to be tailored to meet these needs rather than a blanket approach to "all" local community pharmacies
- Lack of confident and trained pharmacy staff to discuss/assist clients who have chronic diseases and answering questions
- Small catchment area therefore screening and accreditation is not feasible
- Lack of support from the Pharmacy Guild of Australia
- No referral pathways to allied health staff, physios, dental etc
- Education/Continuous Professional Devleopment opportunities can be difficult as health professionals are at different levels
- Funding models and financial constraints are a barrier, particularly in rural Victoria
- The heavy paperwork load for reimbursement is tough (burden) / time consuming

Implications of the key findings

The implications are:

- GPs are not utilising pharmacists as much as they could be in Chronic Disease Management Plans.
- The lack of, or poor communication between pharmacists and GPs/other health professionals is affecting health literacy levels. This is resulting in poorer health literacy and self-management outcomes for clients.
- Financial barriers create time restraints and contribute to less suitable spaces to spend speaking privately with clients for consultations.
- Pharmacists and pharmacies are not reimbursed in line or as part of the healthcare team (adequate reimbursement).

Recommendations for the future

The recommendations are as follows:

Policy and Planning –

Recommendation 1:

Develop best practice information (tailored for rural 'one pharmacist' pharmacies), reflecting on those implementing professional services/initiatives that don't interrupt time flow and are known to have better health outcomes for clients.

Recommendation 2:

Partner and work in collaboration with Murray Primary Health Network (MPHN) to understand the capabilities of the HealthPathways program and resources currently available/developed which are suitable for pharmacies.

Systems Integration/Active Relationships –

Recommendation 3:

Follow up visits to each local community pharmacy with Annie Cross, Clinical Nurse Consultant – Chronic Conditions at Gateway Health, providing pharmacies with:

a) Key contacts for Local Consumer Support Groups by Local Government Area
b) Current local Continuous Professional Development opportunities
c) Project summary/key findings
d) Introduce Annie Cross as regional link to follow on with work/suggested recommendations

Recommendation 4:

Sharing project findings with the Central Hume Primary Care Partnership four Health and Wellbeing Local Partnership Groups.

Recommendation 5:

Implement/promote regular local health professional clinical network meetings to bring pharmacists, GPs and other health professionals together – Presentations from Melbourne or new medications on the market.

Recommendation 6:

Support and utilise access to Continuous Professional Development (CPD) opportunities locally that are integrated with other clinicians from around the Ovens Murray area, including local training for providing professional services, wound care etc.

Quality/Continuous Improvement –

Recommendation 7:

Consistent worker/key contact person within the Ovens Murray area for local community pharmacies to contact, and assist with bridging the gap between primary health care staff and community pharmacy staff.

Recommendation 8:

Increase confidence of pharmacy staff to speak with clients/customers about their Chronic Diseases and asking questions to enhance patient care by encouraging pharmacists to utilise the online health literacy training module.

Proposal

Stage Two of Project: built into Central Hume PCP Integrated Care Co-ordinator position (currently vacant) –

- Follow up with all 16 local pharmacies, to complete the survey
- Engage with local support groups and consumers via surveys and/or focus groups to gauge their understanding of the role local community pharmacies in Chronic Disease Management, and the role of other health services.
- Analyse the data/responses from pharmacies, local support groups and consumers to inform development of tailored resource kits for pharmacy staff and condensed handouts for clients (need to be updated regularly).
- Create or collate targeted discussion/conversation prompts for chronic disease indictors, similar to general screening tools/questions for pharmacy staff to know when to refer clients onto other services. (Check with MPHN HealthPathways)
- Create a referral pathways resource. (Check with MPHN HealthPathways)
- Link pharmacists to key documents (consent forms etc) which can be modified to suit individual pharmacies.
- Update regularly the list of key contacts for Local Support Groups by Local Government Area.
- Identify key contact list of local doctors/GPs. (Check with MPHN HealthPathways)
- Identify list of health services available/offered by LGA. (Check with MPHN HealthPathways)
- Identify list of key contacts for health service staff/local health professionals dealing with specific chronic conditions who are happy to be the liaison people for pharmacies e.g. diabetes educators. (Check with MPHN HealthPathways)