AMA

GENERAL PRACTICE PHARMACISTS – IMPROVING PATIENT CARE

Summary

A proposal from the Australian Medical Association for the Commonwealth Government to establish a funding program to integrate non-dispensing pharmacists within general practices.

Pharmacist in General Practice Incentive Program (PGPIP)

Summary

The costs to the health system associated with overprescribing, medication misuse, adverse drug events (ADEs), and preventable hospital admissions are significant.

A study by Picton and Wright (2013)[i] estimated that rates of patient non-compliance with their medications are as high as 33%, and the Australian Commission on Safety and Quality in Health Care (ACSQHC) estimates there are 230,000 medication related admissions to hospitals annually, costing an estimated $1.2 billion (Roughead et al, 2013).[ii]

The Australian Medical Association (AMA) believes that there are significant benefits to be gained from integrating non-dispensing pharmacists within general practices as part of a GP-led multi-disciplinary team. While there has been a strong trend to have allied health professionals and nurses working in GP-led multi-disciplinary teams this, to a large extent, has not included pharmacists.

Independent analysis undertaken for the AMA by Deloitte Access Economics also shows that the integration of pharmacists within general practices will deliver net savings to the health system of the order of $545m over four years, primarily through fewer avoidable hospital admissions and a reduction in the utilisation of medications.

This paper outlines a proposal for the Commonwealth Government to establish a funding program to integrate non-dispensing pharmacists within general practices. Under the model outlined in this paper, pharmacists will assist GPs with medication management to deliver:

- Better coordination of patient care;
- Improved prescribing;
- Improved medication use;
- Reduced medication-related problems;
- Fewer ADEs;
- Fewer hospital admissions (from reduced ADEs);
- Improved health outcomes for patients, including a better quality of life.

Integrating pharmacists within general practices

Rationale

Funding provided under the Fifth Community Pharmacy Agreement provides for approximately 52,000 Home Medicines Reviews (HMRs) in each year of the agreement, but there are about 700,000 patients with co-morbidities who would benefit from a review of their medications. This is a significant gap. In addition, there are more than 7 million patients with chronic diseases (based on Australian Institute of Health and Welfare (AIHW) estimates)[iii] in Australia who could potentially benefit from having their medications reviewed.

A systematic review (2014) [iv] of pharmacists working in collaboration with GPs concluded that "*Pharmacists co-located in general practice clinics delivered a range of interventions with favourable results in various areas of chronic disease management and quality use of medicines*."

Evidence suggests that where pharmacists are integrated within general practices there is greater capacity for interdisciplinary teamwork and the improvement of patient care.[v] Working in collaboration

with GPs in a general practice provides the ideal setting for pharmacists to utilise their complementary skills to ensure the quality use of medicines and the reduction of ADEs in patients.[vi] It has also been shown that where there is an integrated pharmacist conducting HMRs the timeliness, uptake and completion of HMRs is increased.[vii]

Further, the PINCER trial, conducted in England in 2010, found that pharmacists play a critical role in reducing medication errors in general practice. Study findings demonstrated that pharmacist input and collaboration with GPs reduced the frequency of prescription errors and medicine monitoring errors.[viii]

Proposed role for pharmacists in general practice

The role of the general practice pharmacist would not include dispensing or prescribing medication or issuing repeat prescriptions. The AMA proposes that non-dispensing pharmacists in general practice will focus on medication management, in particular:

- medication management reviews conducted in the practice, an Aboriginal Health Service, the home or a Residential Aged Care Facility (RACF),
- patient medication advice to facilitate increased medication compliance and medication optimisation;
- supporting GP prescribing;
- liaising with outreach services and hospitals when patients with complex medication regimes are discharged from hospital;
- updating GPs on new drugs;
- quality or medication safety audits; and
- developing and managing drug safety monitoring systems.

Supplementary activities, depending on the needs of individual practices, could include activities such as patient education sessions, mentoring new prescribers and teaching GP registrars on pharmacy issues.[ix]

Proposed funding model

The most feasible approach to funding pharmacists in general practice is to adapt existing models that have been accepted and shown to work in general practice. The AMA proposes the introduction of a PGPIP that is structured in the same way as the existing incentive payments provided for nurses working in general practice. Introduced during 2012, the Practice Nurse Incentive Program (PNIP) supports an expanded role for practice nurses. Similar to the PNIP, the AMA proposes that PGPIP adopt the following payment structure:

- $25,000 per year, per 1000 Standardised Whole Patient Equivalent (SWPE) where a pharmacist works at least 12 hours 40 minutes per week.
- Incentives will be capped at five per practice, meaning that practices will be eligible to receive up to $125,000 per year to support their pharmacist workforce.
- A rural loading of up to 50% for rural and remote practices.
- To be eligible to receive the pharmacist incentive payment, a practice must:
    - meet the Royal Australian College of General Practitioners (RACGP) definition of a general practice;
    - be accredited or registered for accreditation against the RACGP Standards for general practice and be fully accredited within 12 months of joining the PGPIP;
    - maintain practice accreditation;
    - have current public liability insurance;
    - ensure all practice GPs have current professional indemnity cover;

- employ or otherwise retain the services of a qualified pharmacist;
- employ or retain the services of a GP (including less than one full-time GP); and
- make sure all pharmacists are covered by the appropriate professional indemnity insurance arrangements required by the Australian Health Practitioner Regulation Agency (AHPRA) or by the professional's registration body.

The economic case to integrate pharmacists within general practice

An AMA commissioned independent analysis by Deloitte Access Economics of the AMA's proposed initiative and funding model demonstrates that it would result in significant savings to the Australian health system - totalling $544.87m over four years.

The analysis considers the current costs (base case) of ADEs, overprescribing and medication non-compliance and compares this to the costs of the AMA's proposed initiative. The projections cover the four years from 2015-16 to 2018-19 and take into account costs including the Pharmaceutical Benefits Scheme (PBS), Medicare Benefits Schedule (MBS), hospital and individual expenditures, as well as the cost of the PGPIP.

The analysis shows that the AMA's proposal delivers a benefit-cost ratio of 1.56, which means that for every $1 invested in the program it generates $1.56 in savings to the health system.

The study estimated that around 3,100 general practices would take up the PGPIP and although it would cost the Federal Government $969.5 million over four years, this would be more than offset through broader savings to the health system in the following areas:

- Hospital savings of $1.266 billion – due to reduced number of hospital admissions following a severe ADE;
- PBS savings of $180.6 million – due to the reduced number of prescriptions from better prescribing and medication compliance;
- Individual savings of $49.8 million – reduced co-payments for medical consultations and medicines; and.
- MBS savings of $18.1 million – due to reduced number of GP attendances following a moderate or severe ADE.

A copy of the Deloitte Access Economics paper is attached.

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[i] Picton, A. and Wright, H. (2013) Medicines optimisation: helping patients to make the most of medicines, Royal Pharmaceutical Society, London.

[ii] Roughead, L., Semple, S., and Rosenfeld, E. (2013) Literature review: medication safety in Australia, Australian Commission on Safety and Quality in Health Care, Sydney.

[iii] AIHW (2014) Australia's health series no. 14, Ct. No. AUS 178, Canberra. http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=60129547726

[iv] Tan E.C., Stewart K., Elliott R.A., George J. (2014) Pharmacist services provided in general practice clinics: a systematic review and meta-analysis. *Research in Social & Administrative Pharmacy* 2014; 10(4):608-22

[v] Ibid.

[vi] Freeman C.R., Cottrell W.N., Kyle, G., Williams, I.D., Nissen L (2012) An evaluation of medication review reports across different settings. International Journal of Clinical Pharmacy.

[vii] Ibid

[viii] Smith, J., Picton, C. and Dayan, M. (2013) Now or Never: Shaping Pharmacy for the future. The Report of the Commission on future models of care delivered through pharmacy. Royal Pharmaceutical Society. http://www.rpharms.com/promoting-pharmacy-pdfs/moc-report-full.pdf

[ix] The PSA has recently been commissioned by Coast City Country GP Training in southern NSW and the ACT to produce a resource for pharmacists teaching GP registrars about pharmacy-related matters.