# Te Awakairangi Health Network General Practice-based Clinical Pharmacist Service

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Te Awakairangi Health NETWORK

# Background

- Te Awakairangi = Hutt Valley PHO
- October 2016 - Proof of Concept: determine the value of clinical pharmacists integrated into general practice
- Informed by international and national models
- Three concept practices
  - Practice demographics
  - GP clinical lead
  - Desk space in the practice
  - Access to PMS
- July 2017 – expanded to six practices

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# Objective

- Deliver coordinated, collaborative, professional services from or within a general practice through an integrated approach

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# Practice/System directed

Providing clinical leadership in the use of medicines

Setting up Continuous Quality Improvement processes for monitoring and tracking quality and safe use of medicines

## Clinician/Staff directed

Promotion of best practice and current clinical information - safety net

Support LTC programme

Responding to medicine information queries

### Patient directed

Improving patient safety with the use of medicines, particularly LTC medicines

Provision of in-practice based consults and /or medication reviews

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# What was achieved in 12 months?

## System Improvement

- Clinician time saved
- Improved communication between general practice and community pharmacy
- Systematic change at practice level ⇨ increased efficiency and capability
- Providing a "safety net" for primary and secondary care clinicians
- MDT models emerging

## Improved Patient Experience

- Patient time saved
- Better patient self-management
- Improved adherence to treatment

## Improved Practice Staff Experience

- Improved clinician experience - time & support
- GPs and Nurses feel professionally safer and confident about patient and medication safety
- Whole team involvement in optimising medication related outcomes

## Reduced Acute Demand

- Reduced hospital admissions and readmissions
- Reduced ED attendances

## Improved Clinical Outcomes

- Fewer falls
- Reduced risk of stroke
- Improved glycaemic control
- Improved asthma control

## Extending Independence for Elderly Patients

- Delayed admission to aged residential care
- Reduced risk of falls
- Reduced risk of adverse events

## Improved Patient Safety

- Adverse drug events avoided
- High risk medicines safety improved
- Clinical leadership in the use of medicines provided

## Reduced Pharmaceutical Costs

- Implementation of systematic deprescribing
- Optimal use of medicines
- CQI processes for monitoring and tracking quality and safe use of medicines

# Evidence of Impact: Improved clinical outcomes

Interventions include:

- appropriate monitoring of high-risk medicines
- reduced risk of medicines-related falls
- implementation best practice prescribing
- increase percentage of medicines reconciliation post-hospital discharge
- improved glycaemic (HbA1c) control

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# Practice/System directed: Improved monitoring high-risk medicines

| Patient | Safe and effective use of Methotrexate (MTX) | | | | | | |
|---|---|---|---|---|---|---|---|
| | Patient is on MTX | Indication for MTX | Weekly dose prescribed | Day of the week MTX taken | Weekly folic acid | Query re adverse effects | Appropriate laboratory monitoring |
| | 80 | 80 | 78 | 22 | 55 | 20 | 44 |
| | | 100% | 98% | 28% | 69% | 25% | 55% |

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# Clinician/staff directed: Promotion of best prescribing practice

| | October 2016 | | July 2017 | |
|---|---|---|---|---|
| Total patients | 237 | | 307 | |
| Gout READ code / no prophylaxis | 112 | 47% | 106 | 34% |
| Prescribed prophylactic medication | 119 | 50% | 201 | 65% |
| Prophylaxis and no READ code | 27 | 23% | 69 | 34% |
| sUA test within audit period | 81 | 68% | 164 | 82% |
| sUA result within range | 55 | 46% | 107# | 53% |

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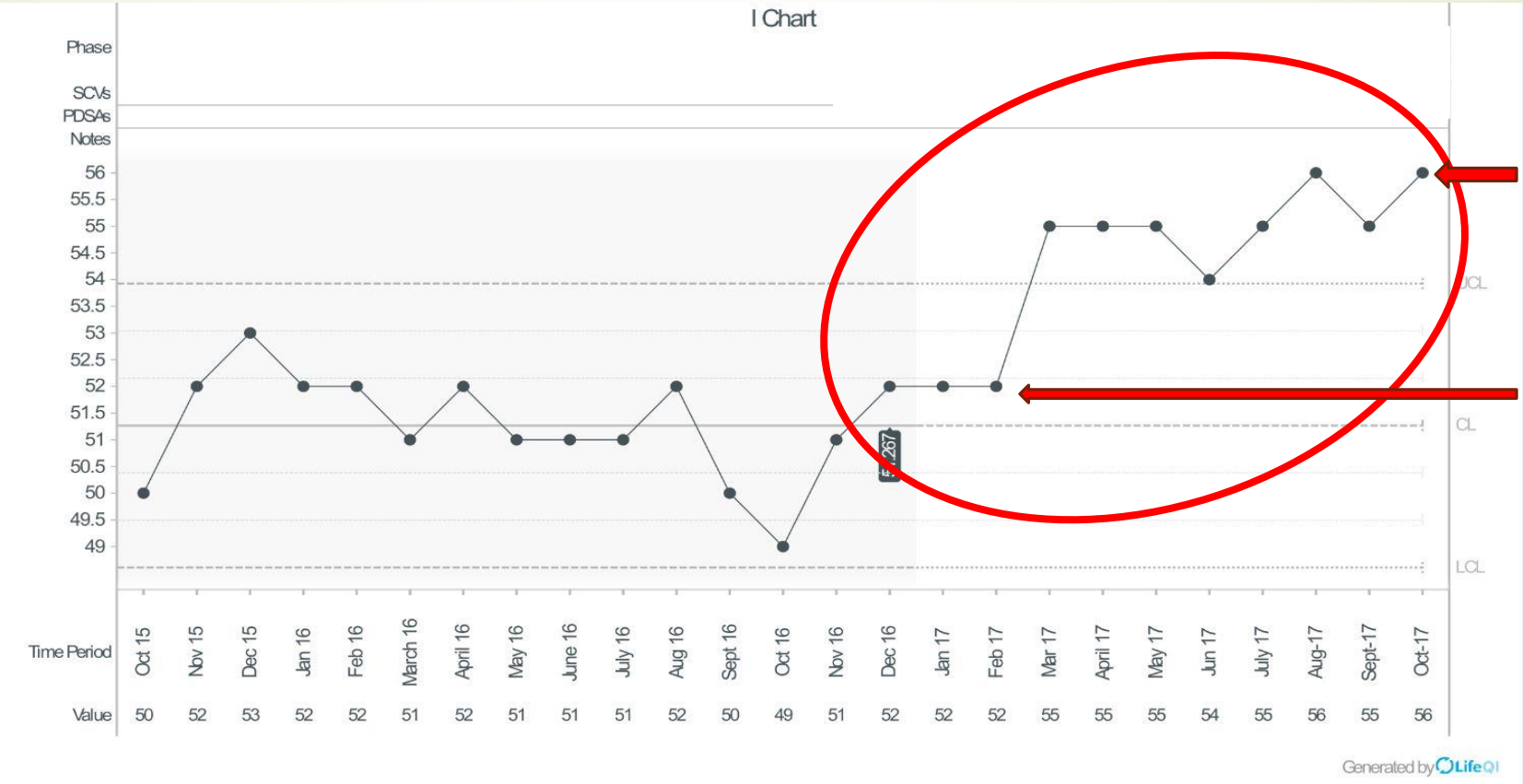
# Patient directed:
# Improved glycaemic control (HbA1c)




56%

51%

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# Evidence of Impact: Reduced acute demand

Achieved through interventions that:

- reduce the risk of medication-related falls in community-dwelling older people
- prevent / reduce hospital admissions/readmissions due to ADRs
- increase number of patients having DAR, with improved diabetes self-management

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# Patient directed: Medicine-related falls risk assessment

- Patients 65+ years
- 10+ long-term medicines
- Evidence-based assessment tool
- 104 patients assessed
  - 46 (44%) had full medication review
  - 13 (12%) low falls risk but full review for different reasons
  - 53 (51%) now prescribed ≤10 long-term medicines

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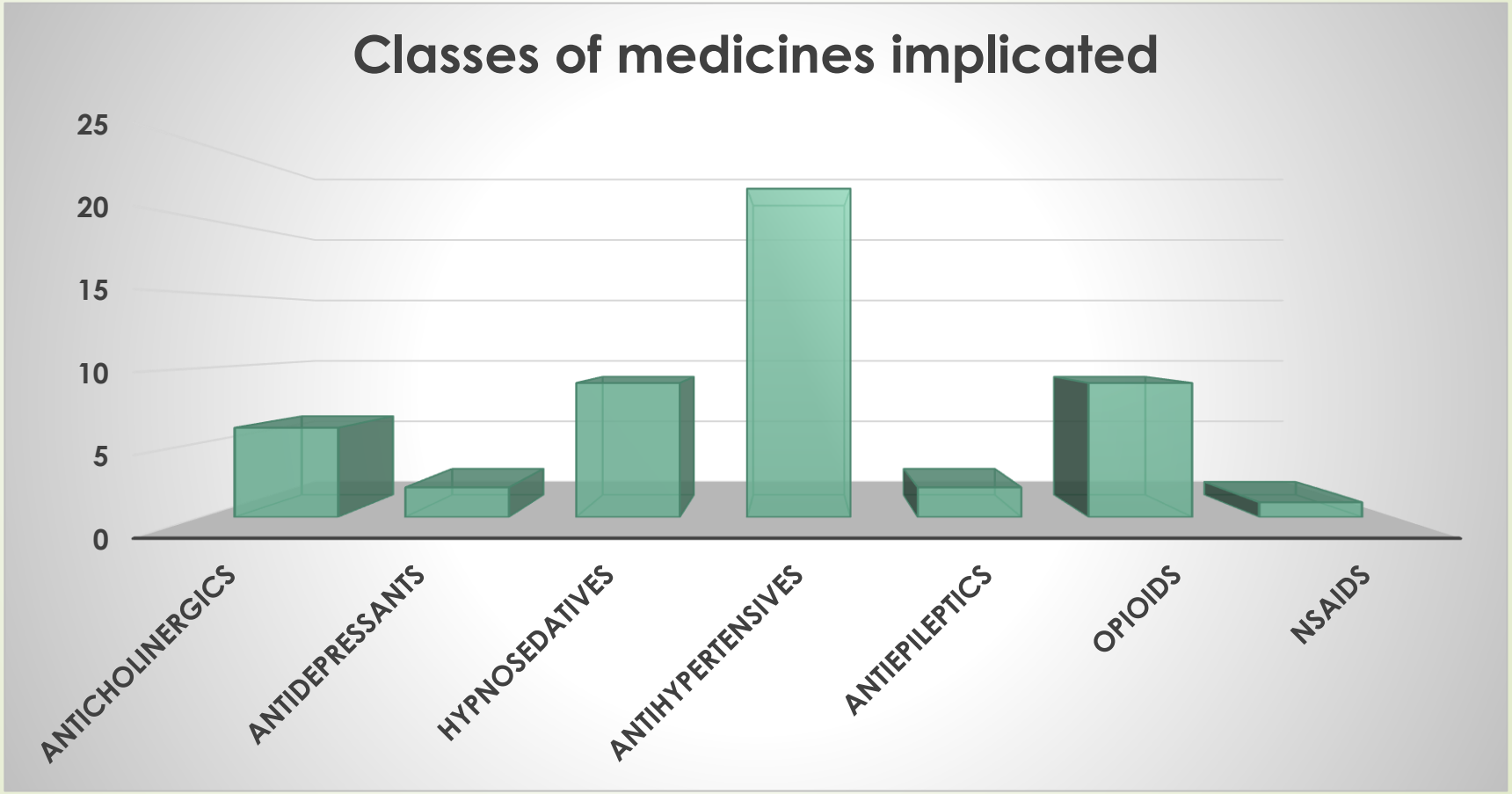
# Patient directed:
# Medicine-related falls risk assessment

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# Evidence of Impact: Reduced pharmaceutical costs

Interventions include:

- improvement in medicines use systems and processes
- reduction of polypharmacy in community-based older people
- resolving intentional non-adherence
- implementation of systematic deprescribing

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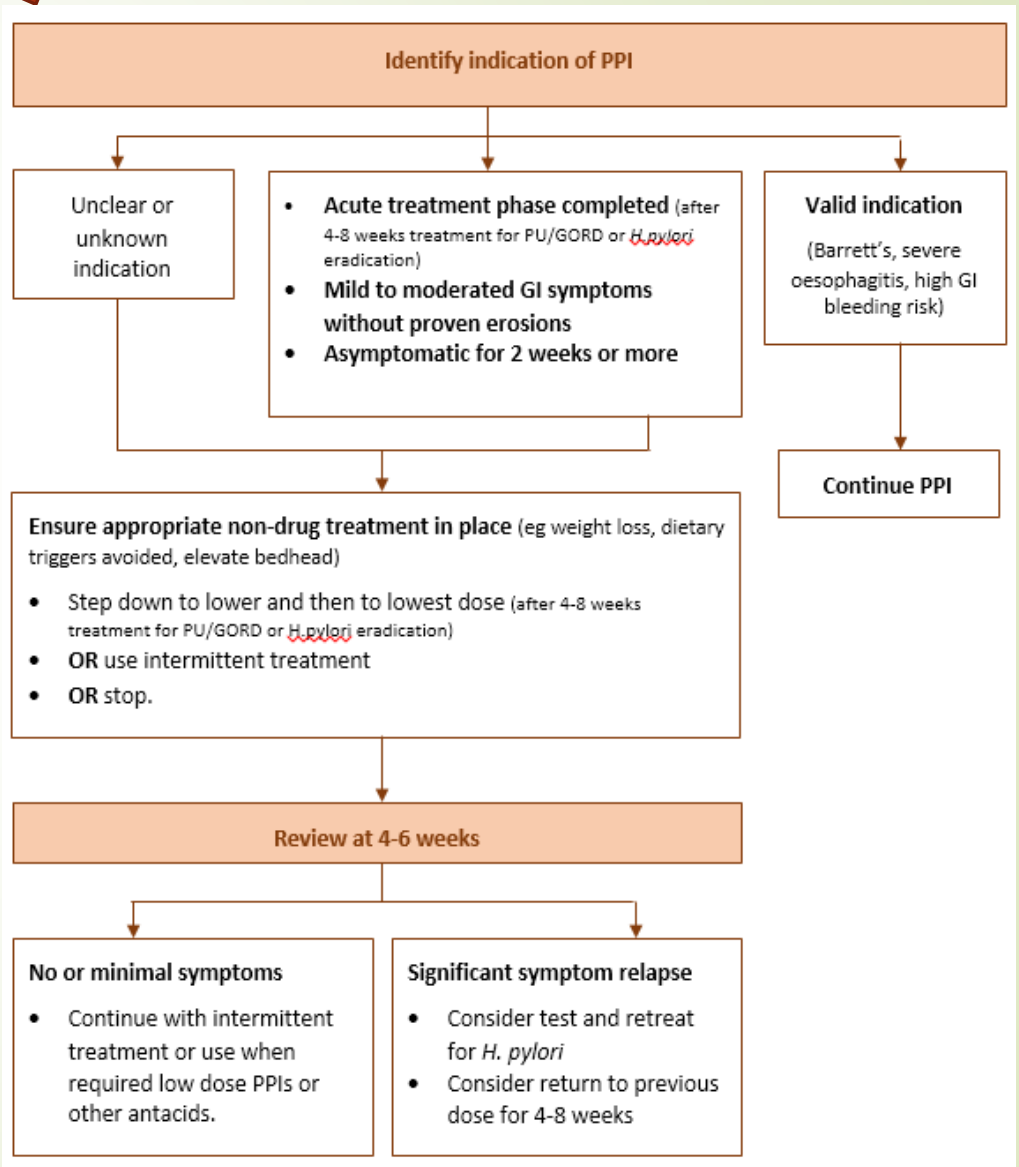
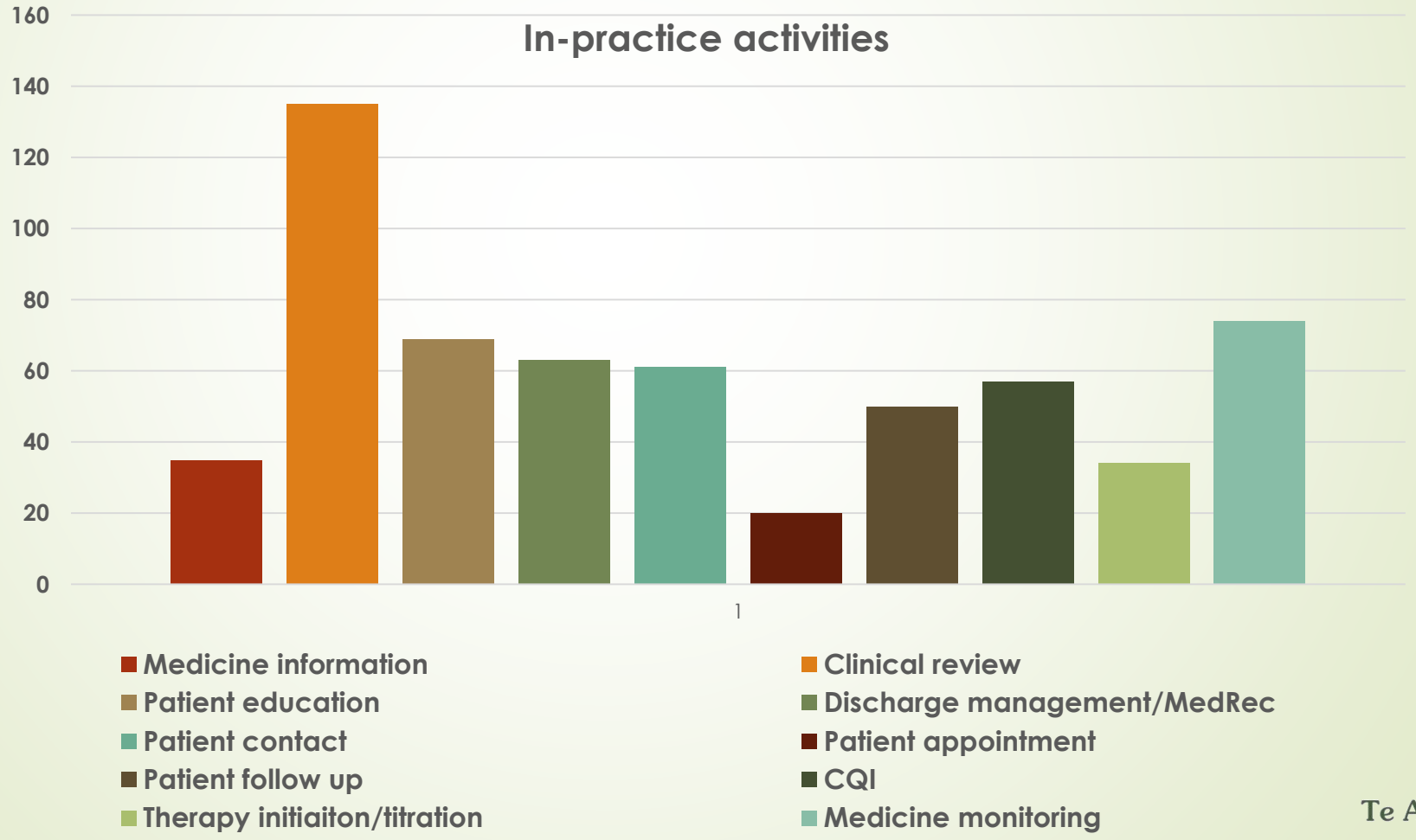
# Practice/System directed

| General tapering guide for acid suppressants | |
|---|---|
| | Withdrawal effects |
| **Halve the dose for four to eight weeks then stop (or step down to a less potent agent). Consider providing an antacid for dyspepsia symptoms** | Recurrence of oesophagitis and indigestion symptoms |
| **PPIs - consider alternate day dosing. Capsules cannot be halved. Consider stepping down to an $H_2$RA if a more gradual taper is required** | Stopping PPIs suddenly can cause rebound hypersecretion of acid |
| **Histamine receptor antagonists ($H_2$RA) - taper gradually** | Rebound dyspepsia has been described after stopping $H_2$RA therapy abruptly |



# Patients impacted: Activity/interventions over 12 months

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# Evidence of Impact: Improved practice staff experience

Feedback included:

- "better insight into complex patients and their medications"
- "expanded clinical knowledge around prescribing and medications"
- "provides holistic integrated model of care for our whānau"
- "her guidance has contributed to improved prescribing knowledge and better clinical outcomes for patients"
- "ensures accurate targeting of areas of clinical concern"

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