# Interim Report: Feedback Survey

The Sustainable Health Review Interim Report feedback survey consisted of 14 questions. The responses to the open feedback questions are detailed below. Responses to questions 9-12 have been published in a summarised report on the SHR website.

| **Your Personal Details** | |
|---|---|
| 1. **Title** | Mr ☐ Miss ☐ Mrs ☐ Ms ☐ Dr ☐ Other ☐ |
| **2. First Name(s)** | |
| **3. Surname** | |
| **4. Contact Details** | |
| **5. Organisation** | The Society of Hospital Pharmacists of Australia (SHPA) |
| **6. Location** | ☒ Metropolitan<br>☐ Regional WA<br>☐ Outside WA |
| **7. Are you providing a response on behalf of your group/organisation or as an individual?**<br>**(Required)** | ☒ Group/organisation<br>☐ Individual<br>☐ Other, please specify: _____ |
| **Q8. Do you consent to your feedback being published, in summaries or in the Final Report? (Required)** | |
| ☒ I consent to my feedback being published<br>☐ I consent to my feedback being published anonymously<br>☐ I do not consent to my feedback being published | |

**The next two questions will allow you to provide more detailed feedback on how to maximise improvements in each of the Directions or suggest other areas or actions for the Sustainable Health Review Panel to consider to develop a more sustainable health system.**

**13. In regards to the 12 Directions, please provide detailed comments on how to maximise improvements in each of the Directions. Where possible, please indicate which Direction your comments relate to.**

"Direction 1: Keep people healthy and get serious about prevention and health promotion

Public health promotions/programs: A more cohesive communication method/strategy is needed to maximise accessibility. Promotions should be free of charge (e.g. TV commercials) or cost a minimal amount (e.g. community information session run by a dietitian about healthy eating). The communication approach (e.g. TV commercial, information booklet, information DVD, information video on the internet, information session/seminar, etc.) is important when considering who we are seeking to influence – especially with varying levels of health literacy, cultures and differences in socio-economic circumstances and background. For example, information about healthy eating could be produced in various languages, be available in written hard copy form and available on the internet, made into an informative video available on the internet or presented as a face-to-face community session.

Cultural awareness in prevention and health promotion: Promotions could be made available in various languages or community sessions could be focused on/cater to certain groups (e.g. Aboriginal presenter for session targeted at Aboriginal consumers – Mary G has been extremely popular (and is WA home grown!).

Consider chronic disease “hot-spots” acknowledged in the Grattan report (Perils of Place ) as having a huge impact on the health of Australians. We should be targeting areas of high need and ensuring our programs match the problem areas. WAPHA have mapped these areas, but there needs to be greater education and collaboration between hospitals and the community sector when dealing with these. Having hospital clinicians aware of the increased risk, focussed on the social determinants of health warrants the SHR close attention. Holistic care relies on a greater awareness of the burden of disease and this goes beyond the “biomedical approach”. Current KPIs and targets focus on the “business of healthcare”, rather than the patient’s business. Measures of patient satisfaction and patient-centred outcomes should be given as much focus as our current “business” indicators - bed-flow, 4-hour rule percentages, length of stay and readmission rates. Patient-centred outcomes need to be developed into ‘real metrics’ and international initiatives , where patients researchers and clinicians come together to ensure voice of the patient takes a central role are worth pursing to ensure sustainable health changes in WA remains accountable and patient-centred care are not simply statements gracing policy documents and brochures.

Preventative Health – Smoking Cessation: Continue to fund programs that encourage people to take up active preventative health, e.g. PBS subsidy of nicotine replacement therapy and support programs. Hospitals are “smoke-free-zones” and a hospital stay provides a special incentive for initiating cessation. Studies have shown that a hospital stay can trigger smoking cessation even in the absence of intervention, especially in patients with cardiovascular and pulmonary disease or in patients having surgery. It is unfortunate that more pro-active approaches such as pharmacist-led smoking cessation programs are not run in WA Hospitals when they are clearly successful in other states.

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Direction 2: Focus on person-centred services

Patients Own Medicines: This initiative aligns well with Directions 2 and 12. Specifically, consumers should be engaged in the context of ownership over their health. Acute care should be viewed as an opportunity to encourage continuity, especially for patients with chronic diseases, where the expectation is that patients manage their own medicines. In these cases, pharmacists could facilitate the continuing of regular medication regimens in formats and ways patients are familiar, supporting self-administration schemes.

Pharmacists are ideally positioned to take on an increased clinical role in delivering pharmaceutical care, ensuring evidenced-based clinical decision making and overall improving the quality use of medicines. Access to and sharing of electronic health information and data, such as My Health Record will help ensure that pharmaceutical care is tailored to the needs of the patient. As encouraged by the Choosing Wisely Australia, pharmacists have the expertise needed to work with consumers and clinicians in identifying medicines with limited or no value and worthy of consideration for deprescribing. They are also uniquely placed to assess higher risk benefit ratio of medicines as well as monitoring clinical progress, treatment efficacy, and side effects. Through their collaboration with other clinicians, pharmacists can reduce the burden of harm in relation to medicines at multiple points in the care pathway.

Patients with the lowest health literacy or interest in their health may be the least able to seek timely medical care (preventative and treatment care) and as such, may pose a greater cost burden to the healthcare system in the long term. Processes for identifying risk and improving access to care should be a focus for this review (e.g. straightforward referral processes, reasonable waiting list times), tailored to their needs (e.g. Aboriginal Medical Services) and should be prioritised.

Closing the loop – Turning discharge into Handover or Transfer of care.

Currently “discharge” is a one- way communication. With patients being discharged quicker and sicker, there are often issues or complications arising which need medical advice and governance after the fact. Building on the success of initiatives such as allied health teams responsible for navigating inpatients with complex needs, and GP liaison positions, consider building interdisciplinary teams with greater community expertise and links (including GPs, nurses, pharmacists and allied health) who are not only accessible for inpatient navigation, but also available to provide advice to community providers where issue arise from acute care episodes. Professor Clifford-Hughes from the NSW Excellence Commission considers the word ‘discharge’ part of the problem, implying “out of sight, out of mind” or no responsibility, or a process to make way for more beds.” While electronic health records may provide a lot more information – the need for communication with a “real-person” cannot be underestimated. The concept of a “warm-handover” needs to be explored and extended, where clinicians consider “high-risk” patients and look to ensure a safer transition of care from hospital to home.

Using technology post discharge to enable integrated care and linkage with GPs for high risk patients.

Knowledge of community services and using telehealth and virtual care should be explored to

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improve access with interdisciplinary teams – especially for high risk patients. There needs to be a way for all clinicians to share the same information, i.e. a common and accessible electronic medical record. Technology should allow sharing and communication of a single "source of truth" about a patient's medical record. In addition to this, My Health Record needs to be widely used and accepted by clinicians and consumers, in order to facilitate communication between clinicians and consumers, and also to enhance ownership and engagement on the part of the consumer

Medication management – hospital liaison pharmacists as coordinators of post discharge care

Recent Australian research confirms discharge from hospital as a point of increased risk, with 61% of discharge summaries containing at least one medication error. Early identification of risk factors including low literacy, recent hospital admissions, multiple chronic conditions or medications, and poor self-health ratings at admission should be undertaken during the hospital stay ~ not just on discharge. The Society of Hospital Pharmacists of Australia's Clinical Pharmacy Standards of Practice strongly recommends engaging an outreach or Hospital Liaison Pharmacist to facilitate continuity of medication management for patients transitioning between care settings. These pharmacists can play a key role in stratifying patients at risk of medication misadventure and exploring the best options for the safe handover of patients through referral to the most appropriate pathway, based on need (i.e. level of risk of medication misadventure) and patient choice.

http://www.asapnet.org/files/June2014/Presentations/ASAPJune14_Presentations01_Sheppard.pdf

Early Supported Post Hospital Discharge for High Risk Patients

CoNeCT Pharmacy has 0.6 FTE pharmacist embedded in an interdisciplinary team (with Complex Needs Coordination team) and has been providing early post discharge supported care since 2014 in the North Metropolitan Health Service based out of Sir Charles Gairdner Hospital. This model based was based on the HARP model (Hospital Admission Risk Program – run out of Victoria) and has been instrumental in developing a validated risk stratification process – to provide medication management services from a Senior Clinical Pharmacist to those patients considered to be at high risk. This service could be up-scaled to reduce risk of readmission, and improve medication safety for our most vulnerable patients. Through use of telehealth and regional hospital pharmacists, there is no reason this service could not be rolled out to all hospitals – metropolitan and regional, especially given the risk stratification process ensures only those patients identified as being high risk are targeted for such a service.

Direction 3: Better use of resources with more care in the community

Duplication of medical tests: It should be easier for all healthcare professionals involved in patient care to access tests, and ensure these are not duplicated (especially where same tests are provided by different laboratories – but patient or GP is not copied in.) GPs and Specialists use the "most convenient" laboratory to provide tests – and if these are not uploaded

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automatically to the GP or hospital system, it is likely these tests will be needlessly repeated. It should be mandatory for Specialists to include the patients usual GP on every test that is conducted. Electronic medical records should reduce this problem, with clinicians able to see what tests have already been done. Decision support tools could also be built into these electronic medical records to help clinicians (e.g. therapeutic drug monitoring has been recently ordered, however the patient has had a change in dose prescribed, so another test could be warranted.)

Community Medication Management Services. There are now more services available with pharmacists providing medication management services in the community. These can be in the form of Home Medicines Reviews (HMRs), MedsCheck or Diabetes Medscheck as an in-pharmacy service, Residential Medication Management Review (RMMR) conducted in aged care facilities and clinical pharmacy outpatient clinics or outreach services from hospital. In addition, pharmacists in emerging roles, employed within, or affiliated with GP practices provide yet another opportunity for a comprehensive medication review in the early post discharge period.

There is a notable lack of awareness of the availability of community medication management services in hospitals. Organizations such as WAPHA are ideally placed to take on the role in mapping the patient journey across care transitions and providing a directory for care in the community and advocating to Government to ensure access to these important services are not "capped" – especially for high risk and vulnerable patient groups. A recent Australian systematic review highlighted that those most in need of medication review remain underserved, including indigenous and Culturally and Linguistically Diverse populations, and those recently discharged from hospital. To date, this work has not been prioritised by WAPHA, perhaps due to the lack of understanding of the risks our patients face on discharge, or difficulties engaging with clinicians on the wards.

Direction 5: New ways to support equity in country health

Hospital staff may not be aware of difficulties country patients face, and more education of staff is needed. This can take the form of professional development for staff, including formal arrangements between regional and metropolitan hospitals, consider interprofessional practice and education principles alongside "traditional" single-disciplinary education approaches.

Direction 6: Develop partnerships for Aboriginal health outcomes

Medication Funding Gaps : Unfunded gaps exist between Commonwealth and State, especially when the patient is transitioning from acute hospital care to the community. There is no provision for hospital supply of Closing the Gap -"CTG" endorsed scripts. This problem has been well described, yet there has not been any progress towards ensuring this gap does not compromise care – especially where patients from the country who have always had their medicines provided for minimal cost to encourage adherence. Metropolitan hospitals do not have an agreed plan to meet the gap, and for services, or aids such as Webster-paks, some hospitals will provide "work-arounds", where others do not. This costs the health system and leads to inequities – depending upon which hospital indigenous patients are admitted to.

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Post-hospital discharge medication risks: Patients from Country are often told to "stay" in the city, but without supports that are usually provided from Communities. Hostels set up to "accommodate" country patients – do only this. They are not set up to assist patients with medication management and where patients have new medicines, or new diagnoses – and no-one to help them, problems inevitably occur. CoNeCT Pharmacy has provided support for those who are occasionally referred, but this has been on an ad-hoc basis. There is an opportunity to ensure there is a dedicated pathway – which importantly includes a qualified Aboriginal Health Worker embedded into interdisciplinary teams to address risks and ensure risks of medication misadventure are mitigated.

Aboriginal Health Workers: Aboriginal health workers provide important support in cultural and social knowledge of Aboriginal health, and should be more fully integrated within teams, rather than operating as "satellites" in the hospital system. [redacted] Royal Perth Hospital demonstrates an example of this embedded approach of the Aboriginal Health Worker working closely with the Cardiology team and the Aboriginal GP Liaison Offer. This should be seen as an exemplar service. More needs to be done across and within professional organizations to embrace credentialling and support AHWs in their important work. In the Kimberley, Aboriginal health workers play an important role in the delivery of HMRs to Aboriginal patients and their unique contribution needs acknowledgement and facilitation to grow and develop to improve medication management in our indigenous Australians.

Simplify prescribing across the whole sector: While Aboriginal Controlled Community Organizations and Communities adhere to a standardized approach to medications, hospitals have not been keen to embrace this formulary. The Kimberley Standard Drug List (KSDL) has been available for many years. The KSDL was developed as a joint project by regional healthcare providers based on clinical evidence, existing patterns of use and multidisciplinary consensus. A standard approach to treatment helps ensure that patients will be able to access the same medications in the places they live and visit. It also increases the familiarity of professionals and patients with the range of medicines used and reduces the likelihood of medication error.

The opportunity for residents to have guaranteed access to standard medicines and treatment protocols across the Kimberley was a positive step towards improving medication adherence and this initiative should be recognised for the important value and safety it provided. There should be no excuse for hospitals NOT to provide this for patients who are treated under the ACCHO scheme, especially since we have moved to having a State-Wide Formulary.

Education and integrations of cultural awareness: While the eLearning package for staff is great, more could be offered to staff to equip them with practical skills and knowledge to look after Aboriginal consumers, e.g. ways to optimise communication and engagement, information about assistance programs available to Aboriginal patients, especially those from regional areas.

Direction 8: Greater use of technology, data and innovation to support consumers, clinicians and drive change

~~Hospital wide Electronic Medication Management Systems (EMMS), when fully implemented,~~

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make hospitals safer places to prescribe, review and administer medicines. In other Australian states and territories, and internationally, EMMS has demonstrated benefits in improving the clarity and quality of prescribing, reducing dose omissions and acting as a clinical decision support tool at the point of care. WA is the only state that has not implemented ePrescribing for inpatient medicines management (with the exception of MetaVision® in the Intensive Care Unit of the Fiona Stanley hospital). EMMS can also offer the opportunity of much better insight into prescribing and other medicine related activities through data analytics at different levels.

Implementation of electronic medication management systems (EMMS) as part of an electronic medical record will;

reduce prescribing and medication administration errors, expedite discharge reconciliation and generation of discharge prescription processes, supply current and complete medicines lists to the discharge summary, and provide better information through data analytics on prescribing activities to inform initiatives and programs that aim to improve quality use and cost-effectiveness of medicines –such as the Choosing Wisely Program©.

Commitment to resourcing across all hospital sites (including importantly regional hospitals) is required (including funding) for technologies to enable streamlined and secure electronic systems, which are to be used consistently across the state, to communicate patient information (e.g. medical records, dispensing history). Paper records or information which is inaccessible to patients and/or other health care providers (e.g. dispensing history at a particular pharmacy) can contribute to fragmented care and inefficient communication between patients and health care providers across the sectors of health care.

In developing and implementing approaches to data sharing, it is important to ensure consumer engagement throughout this process. Consumers need to then “educated” about what data sharing means for them (i.e. who can see their data or what data can be seen) and how to be active participants in their digital health record.

Direction 9: Harness and support health and medical research collaboration and innovation

Research funding opportunities in hospitals and through WA Health should be linked to objectives and directions of the SHR. Universities should be incentivised to drive research in these areas in order to align with Direction 9. There needs to be greater collaboration for research to meet the needs of patients. Co-designed research, which fits the health agenda and the patient needs should be a focus.

Direction 10: Develop a supported and flexible workforce

At present, some WA hospital pharmacy departments deliver a skeletal weekend pharmacy service focused on medicines supply, if at all. This is despite AIHW data showing that there are proportionately more presentations to the emergency department on weekends than on most weekdays. There are currently gaps in the provision of clinical pharmacy services available in acute care hospitals across weekends. Addressing this in an equitable way and appropriating pharmacy resources of areas with highest need requires urgent action. Even during weekdays,

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pharmacy resources should be targeted through a triage model focusing on patients at highest risk of medicines mismanagement, with commensurate and appropriate pharmacy resources to be deployed in hospital pharmacy departments.

Traditionally, hospital pharmacists have only had capacity to target their care to patients at admission and discharge; however, to promote patient safety and excellence in hospital pharmacy practice, commitment to full clinical pharmacy services across seven days is required. This needs to take factor in how current hospital pharmacy teams allocate their scarce resources and prioritise direct frontline care. It also needs to take into account the challenges presented through urgent unscheduled care, as well as scheduled care. This requires thoughtful consideration to exactly what clinical activities need to be prioritised on both weekdays and at weekends, and what role remote and/or mobile consultations could play in ensuring adequate pharmacy coverage. Extending to seven-day clinical pharmacy services at all hospitals will increase the proportion of patients who can be reviewed for medication reconciliation, and monitoring of medicines whilst hospitalised and improve continuity of care at discharge.

As hospital pharmacy evolves and expands its scope of practice, from dispensary-based supply functions to team based patient-centric roles, the need to effectively harness the pharmacy technician and pharmacy assistant workforce becomes paramount. SHPA is currently prioritising development of advanced level competencies, where pharmacy technicians/assistants can undergo credentialing for specific practice areas with national certification, enabling movement between hospitals across Australia, and ensuring the ongoing development of the profession in partnership with pharmacists to provide enhanced patient care. Assisting WA hospitals in this workforce redesign through upskilling pharmacy technicians to prepare dispensed medications for discharge and partake in medication reconciliation can reform pharmacy services and improve patient care.

Direction 12: Building financial sustainability, strong governance, systems and support service

Medicines remain the most common therapeutic intervention available to clinicians; however, the burden and cost of harm relating to medicines is well reported. As incidents often have multiple causational factors, many involving human error, they often require a multifaceted approach for mitigation.

The more successful strategies for systematic improvement involve forcing functions and computerisation, with policies, rules, education and training being important but less effective in changing human behaviour.

Between July 2016 and June 2017 [redacted] medications were the most frequently reported incident type accounting for about 24% of all incidents. [redacted] WA has reached a ceiling of safety improvement with paper systems for prescribing, administration and review of medications. (As demonstrated in 2 state-wide NIMC audits in 2012 and 2014).

As mentioned in Direction 1, the use of Patients own Medicines Specifically, consumers should

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be engaged here in the context of ownership over their health, and acute care representing the continuation of a patient's medical management for chronic diseases (which are largely managed by themselves at home).

As mentioned in Direction 8, electronic medicines-related data is important to guide safe, therapeutic and cost effective management of patient care. This data assists WA Health in ensuring judicious prescribing and cost containment which support financial sustainability for our future. iPharmacy can provide information about medicines usage/supply in hospitals, and there is the potential to combine this with PBS linked data and NaCS clinical data to have a much better overview of prescribing and usage of medicines in our health system. Electronic medication management systems can deliver a greater depth of prescribing and administration information to provide a comprehensive picture of medication management in the hospital setting.

Systemwide analysis of major areas of expenditure and cost growth must include high cost of medications. WA Health needs to understand prescribing trends to make smarter choices across the system.

This information should be shared with support for its interpretation and use in research in order to align with Directions 8 and 9. To achieve this, coordination of business intelligence should be prioritised, as well as ensuring that capability of area health services is supported in both infrastructure and human skills.

If WA Health want a more sustainable, safe and accountable system for managing patient care, we need to invest in a closed loop electronic medical record which includes e-prescribing capability within a clinical information system and interfaces with pharmacy software, to ensure we are providing efficient, equitable and patient centred care to follow patients throughout their journey seamlessly across the health system.

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**14. Is there anything else that the Panel has missed so far that is important in developing a more sustainable health system for Western Australia?**