

CLOSING THE GAP

Pharmacists in Aboriginal health

BY JARRYD LUKE

Pharmacists working in Aboriginal Health Services (AHS), with the support of recent Government reforms, are playing a key role in closing the gap and helping Aboriginal and Torres Strait Islander patients navigate Australia's complex health system.

This year marks the 50th anniversary of the 1967 Referendum, when the overwhelming majority of Australians voted to include Indigenous Australians in the Census and allow the Commonwealth to make laws for them.

Next year marks the tenth anniversary of the Closing the Gap program, established by the Council of Australian Governments (COAG) in 2008 with the aim of eliminating the gap in health, education and employment disadvantages between Indigenous and non-Indigenous Australians.

In acknowledging of these important milestones, this year's annual Closing the Gap Prime Minister's Report said: 'While we celebrate the successes we cannot shy away from the stark reality that we are not seeing sufficient national progress on the Closing the Gap targets. While many successes are being achieved locally, as a nation, we are only on track to meet one of the seven Closing the Gap targets this year.'¹

The health-related targets of halving the gap in child mortality and closing the gap in life expectancy are not on track.

Some of the targets will expire in 2018, so governments have 'agreed to work together with Indigenous leaders and communities, establishing opportunities for collaboration and partnerships.'¹

According to PSA CEO Dr Lance Emerson, 'Aboriginal Australians are four times more likely to be hospitalised for chronic conditions compared with non-Indigenous Australians – and the life expectancy of Aboriginal people in this country is 10 years lower than non-Aboriginal people – and in fact below that of many developing countries such as Bangladesh.

'This reality is disgraceful in a rich country such as Australia,' Dr Emerson said. 'Health professionals need to be doing all they can to work toward deeper understanding and meeting the needs of Aboriginal people, to support reconciliation and self-determination – and Aboriginal peoples' community control of services provided for Aboriginal people.'

The Government has implemented several programs to provide timely and affordable access to PBS medicines and Quality Use of Medicines (QUM) (listed opposite). However, the Review of Pharmacy Remuneration and Regulation Interim

CURRENT GOVERNMENT PROGRAMS

- Section 100 Remote Area Aboriginal Health Services (RAAHS) Program
- Section 100 Pharmacy Support Allowance Program
- Quality Use of Medicines Maximised for Aboriginal and Torres Strait Islander Peoples (QUMAX)
- Closing The Gap (CTG) PBS Co-Payment Measure.



< (L-R): Mike Stephens and Kira McKenzie at Tasmanian Aboriginal Centre, Hobart.

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— FEDERAL HEALTH MINISTER
GREG HUNT

Report noted in June that ‘although they are related, these programs operate independently with differing eligibility criteria applied for each. This raises difficulties for both consumers in terms of access and for pharmacists and other health professionals with respect to administration.

‘In considering how pharmacy options may contribute to improved health outcomes for Aboriginal and Torres Strait Islander people, the Panel has questioned whether currently arrangements are sufficient and how might they be improved.’²

Integrating pharmacists

The Federal Government has committed to implementing reforms and investigating new funding models to help pharmacists continue to improve health outcomes of Indigenous patients.

In his opening speech at PSA17 in Sydney in July, Federal Health Minister Greg Hunt announced a trial, funded through the Pharmacy Trial Program (PTP), to support AHSs to integrate pharmacists into their services.

The trial has strong stakeholder support amid growing evidence that pharmacists employed by Aboriginal Community Controlled Health Organisations (ACCHOs) can help increase patients’ life expectancy and health outcomes.

‘As a country, we will not have fully succeeded unless and until Indigenous health outcomes are the same as non-Indigenous health outcomes,’ Mr Hunt said. ‘That’s our very simple shared goal.

‘We will work immediately to have Indigenous-specific medication reviews available and we will fund and support that as part of Tranche 1 to make sure they are culturally specific.

‘We want in these Aboriginal Health Services to ensure there’s a pharmacy presence. The first line there is to see if we can have a direct link and an offer to community pharmacists to participate, but where that’s not possible, the breakthrough agreement ... is that the Aboriginal Health Services will be able to directly employ a pharmacist.’

This announcement follows the Review’s Interim Report recommendation to trial the ability for AHSs to employ pharmacists and operate a pharmacy because ‘the current inability of an AHS to operate a community pharmacy poses a significant risk to patient health in some rural and remote areas.’²

The Panel presented the option that: ‘All levels of government should ensure that any existing rules that prevent an AHS from owning and operating a community pharmacy located at the AHS are removed.’ The Panel suggested that as a transition step, these changes should first be trialled in the Northern Territory.

PSA National President Dr Shane Jackson said having a culturally responsive pharmacist integrated within an AHS builds better relationships between patients and staff, leading to improved results in chronic disease management and QUM.

‘Integrating a non-dispensing pharmacist in an AHS has the potential to improve medication adherence, reduce chronic disease, reduce medication misadventure and decrease preventable medication-related hospital admissions to deliver significant savings to the health system,’ Dr Jackson said.



Director of Medicines Policy and Programs for the National Aboriginal Community Controlled Health Organisation (NACCHO) Mike Stephens welcomed the announcement of the trial.

'We know from recent studies, including systematic reviews, that pharmacists delivering services within a practice setting can have a significant impact on health outcomes,' Mr Stephens said. 'While there is some level of role translatability between ACCHO and non-ACCHO sectors, we really don't know where the "sweet spots" are in terms of health outcomes, community demand and value for money when embedding pharmacists in ACCHOs.'

'There are a lot of different activities happening from ACCHO to ACCHO. The approach needs to be flexible and responsive to communities' needs, as well as integrated into the holistic care models ACCHOs use, but the detail on what has the biggest health impact is unknown.'

'Current ACCHO pharmacists have shown an opportunity to bring players together and make medicines a team sport – this includes the pharmacist working with allied health, GPs, nurses, Aboriginal Health Workers (AWH) and a range of local community pharmacies, hospitals, PHNs and more to get the best results for their clients and community as a whole.'

Mr Stephens said some ACCHOs are also hiring intern pharmacists and pharmacy technicians, allowing pharmacists to focus more on clinical, education and practice-based activities that work well in a general practice setting.

'These pioneers are also promoting the newer roles of pharmacists. I see a lot of pharmacists focusing on systems-based activities like clinical governance, DUEs and audits, as well as working across teams in and outside of the organisation, such as improving transitional care with local hospitals.'

Mr Stephens said there had been 'a lot of interest' in the trial from NACCHO's Members Services.

'Research has shown that access and acceptability of pharmacy services could be improved.'

Feedback from ACCHOs indicates the benefits of embedding pharmacists can be diverse, but may include improvements in clinical governance and prescribing practices, internal and external workflow, MMR uptake and relationships with community pharmacies.'

Sharing ideas

In recognition of the growing number of pharmacists working in ACCHOs, PSA and NACCHO launched the ACCHO Special Interest Group (SIG) at PSA17.

Dr Jackson said pharmacists working in ACCHOs had specific needs and skills and developing a SIG to support them will help drive the growth of this career path.

'In many cases, pharmacists working in these positions are providing innovative and diverse services that have the potential to be informative and relevant to the evolution of pharmacy services and inter-professional care,' Dr Jackson said.

The ACCHO SIG will allow PSA and NACCHO to foster collaboration, inform relevant policy and consult with ACCHO pharmacists about their needs. The ACCHO SIG will also support pharmacists participating in the Aboriginal health organisations trial.

Mr Stephens, who convened the ACCHO SIG, said the key aim was to share resources and ideas and give each other support in a relatively niche area.



"Current ACCHO pharmacists have shown an opportunity to bring players together and make medicines a team sport."

– MIKE STEPHENS



^ (L-R): Pharmacy Support Worker Ines Francia, Mike Stephens, and Regional Pharmacist Lakis (Lucky) Zeniou at the Institute for Urban Indigenous Health (UIH) in Brisbane.

'I have learnt a lot from each of the participants and their input has definitely shaped my clinical practice and policy output. I hope the SIG can evolve organically as needs and issues develop.'

Mr Stephens said optimising medicines use for Aboriginal and Torres Strait Islander people has been an ongoing challenge.

'Despite some great programs, policy and resources, Aboriginal PBS utilisation is still only about two-thirds of non-Indigenous Australians' use. Most pharmacists would have heard of Closing the Gap prescriptions but how is that delivering outcomes? How could it be improved? We have responded to this question and more in a recent submission to the Review of Indigenous Pharmacy Programs. There is a real sense of goodwill from many industry players in this area at the moment.'

Mr Stephens said that, in addition to the SIG, a more informal network has been set up for any pharmacist or other health professional with an interest or expertise in Aboriginal and Torres Strait Islander medicine issues. NACCHO shares a monthly medicines bulletin with the network, including practical resources and links.

Mr Stephens described his previous workplace, Danila Dilba Aboriginal Health Service in Darwin, as a dynamic multidisciplinary environment.

'It opened my eyes to the details of how a large holistic health service works, and how general practice and other primary care services fit into that. I did everything from HMRs to pharmacy accounts, board briefings to Drug Use Evaluations (DUE) and clinical governance, GP education and much more. The team vibe was great and I had a lot of fun with colleagues from different disciplines and backgrounds.

'The challenge was the complexity and nuances of community relationships and systems, and learning where your skills will work best. Engagement is critical and I saw some programs struggle because clients and employees were not driving the change.' Mr Stephens is a strong believer in lifelong learning and found PSA's *Guide to providing pharmacy services to Aboriginal and Torres Strait Islander people* invaluable.⁴

ACCOS

Aboriginal Community Controlled Health Organisations (ACCHOs) are non-government organisations operated by local Aboriginal and Torres Strait Islander communities to deliver healthcare to the communities that control them, through an elected board of management. Types of organisation in the sector include ACCHOs, government-run organisations and other non-government organisations. In 2015–16 these organisations provided healthcare services to around 461,500 clients through 3.9 million episodes of care.³

Aboriginal Health Service (AHS) is a general term for organisations that may or may not be community controlled.



'It has a lot of detail but is applicable for pretty much all pharmacists across Australia, and it has some great case studies. It was developed by a range of organisations and people with lots of experience.

'There's never been a better time to upskill and get involved, with PSA's support modules for Aboriginal Health Services Pharmacists, the ACCHO SIG and the network. NACCHO can also provide support for pharmacists looking to get involved.'

PSA provides CPD, training, practice support tools and recommended external resources to support AHS pharmacists.⁵ This includes an essential guide as well as guidance on networking and advancing within this career pathway.

Building rapport

Vanessa Bickerton MPS, a hospital pharmacist from Perth, previously worked at Wirraka Maya Health Service in South Hedland in the Pilbara region, 1,600 kilometres north of Perth. She said it was a challenging but uniquely satisfying role.

'Though it took some time to establish relationships and build rapport with patients, the pharmacy service was integral to the organisation,' Ms Bickerton said.

As part of a diverse team of doctors, nurses, AHWs, pharmacists and other allied health professionals worked closely with patients in communities that sometimes had limited access to medical care.

'This included supply to even more remote nursing stations, such as Marble Bar, Nullagine and Yandeyarra – where due to geographical challenges the Royal Flying Doctor Service only visits once or twice a week,' Ms Bickerton said.



“Developing meaningful rapport with patients also took significant time – like with any small community people can be slow to trust a new face!”

– VANESSA BICKERTON MPS

‘The opportunity to visit some of the local Indigenous communities gave me great insight into the challenges faced by the Australian healthcare model – the challenges for patients and healthcare providers in finding solutions that are sustainable and workable for all parties.’

Ms Bickerton said the accessibility of the healthcare service within South Hedland was excellent.

‘The Aboriginal Medical Service (AMS) had the capacity to collect patients from home who otherwise wouldn’t be able to come into the clinic. The clinic didn’t require appointments, so patients could simply come when they needed review, and wait for the next available doctor.’

But the challenges in providing timely healthcare to communities farther out of town increased exponentially.

‘Managing and pre-empting manufacturer supply problems can be near on impossible, and they are exacerbated when delivery to some communities only occurs once weekly.

‘Developing meaningful rapport with patients also took significant time – like with any small community people can be slow to trust a new face! Cultural differences can mean patients in remote areas are sometimes more transient than “city folk” are used to. Patients from other areas such as Broome or Bidadanga would regularly show up at Pilbara Pharmacy Services (PPS) with no medicine.’

Language barriers meant it was sometimes difficult to learn where the patient was from and what medicines they needed, but the AHWs and pharmacy contacts at other AMSs could usually help piece things together.

Another significant challenge was improving patient compliance and health literacy.

‘In collaboration with AHWs and the Wirraka Maya Health Service, PPS produced some patient education tools specifically targeted to high-risk groups within the service. Different values and belief systems around health add an additional layer of complexity to this kind of care.’

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A DAY IN THE LIFE



Alice Nugent MPS is an accredited pharmacist working in several AHSs around Dubbo in regional NSW.

After completing her pharmacy studies, Ms Nugent travelled around Australia until a three-month locum in Darwin turned into an eight-year role in a large community pharmacy.

She travelled thousands of kilometres across the Northern Territory by 4WD, plane and boat to ensure remote areas had timely access to quality medicines. It was here that she developed a passion for rural and Indigenous health.

Ms Nugent returned to Dubbo to be closer to her family and started working in a number of AHSs, where her average workday includes a variety of tasks.

7.30 AM

Drive 45 minutes to the small rural town I visit once a week.

8.30 AM

Hold team meeting with GPs, nurses and health workers. Discuss clients who have been in hospital – I will organise a HMR referral including up-to-date pathology, specialist letters and clinical notes.

9.00 AM

Talk with GP about a mental health patient I did a home visit for last week. I discovered he had not been taking all his medication and was feeling unwell. He avoided being admitted to hospital this time and is being followed up by mental health services.

9.30 AM

Prepare information for the GP for a patient on multiple mental health drugs including Sodium Valproate, who wants her Implanon contraceptive implant removed. I offer to talk to the patient.

10.00 AM

See a new patient in the clinic who has brought in their bag of medications. Discard half of them, enter the list in the computer system and make some notes for suggested changes for the GP.

10.30 AM

Help one of the reception staff who has just started doing her health worker training with an assignment question 'What is QUM?'

10.45 AM

Liaise with the local hospital who supply our imprest stock to update our formulary to include some extra medication for emergency treatment of migraine.

12.00 PM

Join fortnightly integrated care meeting with hospital care coordinator, Indigenous liaison officers, diabetes unit staff and practice nurse to discuss patients who have been in hospital or at high risk. I will organise HMRs for some recent discharges. The diabetes unit ask me to talk to one of their patient support groups.

1.30 PM

See a patient in the clinic for a non-claimable HMR. A home visit wasn't possible as the patient seems to be technically homeless. They are living between relatives and weren't sure if it would be ok for me to visit the current house.

2.30 PM

Home visit for HMR with Aboriginal Health Worker. She checks BP, INR and BSLs while I check medications. This is a very common scenario of multiple medications for diabetes, heart disease, renal impairment and mental health issues. Visits tend to take a while as it is important to listen, discuss family issues and build relationships. The patient thanks us for our help and suggests we also visit two of his brothers. I will write up the HMR later and the health worker will help the patient with some disability support paperwork.

4.30 PM

Review my patient notes in the computer system and highlight those who would benefit from an appointment with me in the clinic or a HMR.

5.00 PM

Spend the drive home thinking about how much more I could do if I was funded for more than one day a week. I would love to spend more time talking to patients to help them understand it is important to take your medicine the right way, so it helps you feel better and live longer! This is my definition of QUM.