Geriatric Medicine Outreach Pharmacist Services

HOSPITAL PHARMACY PRACTICE UPDATE

SHPA Transitions of Care and Primary Care Leadership Committee
SHPA Geriatric Medicine Leadership Committee

The Society of Hospital Pharmacists of Australia (SHPA) has produced this guidance document for use by health organisations looking to embed the role of a Geriatric Medicine Outreach Pharmacist in geriatric community care settings.

Purpose

As recommended in SHPAs position statement on geriatric medicine and aged care clinical pharmacy services[1], the inclusion of Geriatric Medicine Pharmacists in broader hospital-based interdisciplinary aged care outreach services are essential for achieving better health outcomes for older people. The purpose of this Hospital Pharmacy Practice Update is to:

- define the role of a hospital-based outreach pharmacist service in geriatric community care settings
- describe potential beneficial outcomes of a hospital-based outreach pharmacist service for older adults
- outline the core service elements for a hospital-based outreach service led by a geriatric medicine pharmacist

Background

In Australia, it is estimated that around 30% of all hospital admissions of older people are medication-related, and approximately half of these are preventable.[2] The use of medications in older adults is complex and compounded by higher rates of chronic disease burden, many which require treatment with multiple medications. Up to 40% of people aged over 75 are dispensed 5 or more medications.[3]

Medication management involves prescribing, dispensing, administering, and monitoring medicines[4]. This focus makes the medication management process a responsibility not only for the consumer, but one shared across multiple members of the interdisciplinary team that are involved in each of the stages of the consumer's care. In the cohort of older people in particular, medication management can be complex due to the following barriers:

- taking multiple medications (polypharmacy)
- taking potentially inappropriate medications or doses
- multimorbidity
- having multiple prescribers
- cognitive or sensory impairment
- declining hepatic and renal function
- reduced manual dexterity
- dysphagia
- poor health literacy
- multiple transitions between care settings
- psychosocial and sociocultural issues

Glossary

Geriatric Medicine Pharmacist – Pharmacists who provide care to older people regardless of whether the pharmacist works in a specialist geriatric medicine service or another setting that provides care for older people

Geriatric Medicine Outreach Pharmacist – Pharmacists who provide clinical pharmacy services targeting older people outside of a hospital setting to prevent hospital admission or readmission

Geriatric Community Settings – Including, but not limited to: Independent living, in-home aged care, short-term aged care (transition care programs, restorative care, respite care) and residential aged care

Defining the role of geriatric medicine outreach pharmacists

Older people are frequently hospitalised following a significant health event such as an infection, fall, stroke, renal failure, or cardiac arrest. As a result, their medication regimen may also change significantly. As identified in the Royal Commission into Aged Care Quality and Safety: Final Report[5], the work of Geriatric Medicine Pharmacists employed in residential care services, and in all settings where older people receive care, can significantly improve the use of medications and patient health outcomes. The ongoing implementation of embedded pharmacist positions to improve medication management and safety for aged care residents, will thus continue to be a priority area for the aged care sector.

Geriatric Medicine Pharmacists who care for older people have specific geriatric medicine knowledge and expertise. These highly skilled healthcare professionals may be employed by hospitals, residential aged care facilities (RACF), home care services, general practice clinics, community pharmacies or they may work as independent contractors. They work in collaboration with doctors, nurses, and allied health professionals to provide direct patient care as well as supporting high-quality clinical governance.

Geriatric Medicine Pharmacists working in interdisciplinary teams ensure that treatment is rational, safe, cost-effective and aligned with the person's healthcare goals and preferences. This care has the potential to be extended to outreach services where Geriatric Medicine Outreach Pharmacists can provide care in geriatric community settings, face to face or virtually via hospital-based telehealth services.

Geriatric Medicine Outreach Pharmacists support the transition of care process by:

- reviewing the persons medications
- ensuring they are correctly and safely taking or receiving their medications
- confirming the medications prescribed align with the persons overall goals of care
- the intended weaning or cessation of medications post-discharge has occurred

Evidence shows that pharmacist-led comprehensive medication reviews can optimise medication use in this patient group by decreasing sedative and anticholinergic burden – both of which are further compounded by inappropriate prescribing.[6] Recent Australian studies also demonstrate the positive impact of geriatric medicine pharmacist positioned in RACF, including reduced hospital readmission, reduced inappropriate dosage form modification, and increased medication safety through documentation of allergies, adverse drug reactions, and medication incidents.[7,8]

Utilising hospital-based geriatric medicine pharmacists in aged care outreach services could provide an extra step in ensuring patients get the most benefit from their medicines, and most importantly, stay out of hospital.

Key benefits of including geriatric medicine pharmacists in aged care outreach services

1. **Reducing preventable medication-related hospital admissions**
2. **Reducing medication errors across transitions of care**
3. **Improving the safety and quality use of medicines**
4. **Providing advice on aged care policy setting and guidelines**

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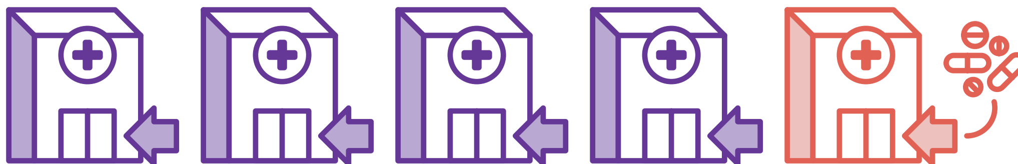
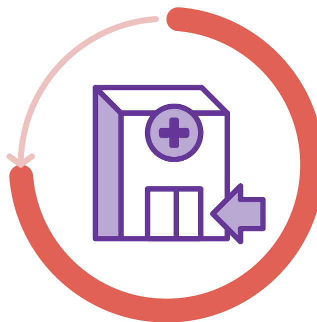
The interface between the hospital system and the aged care system can be divided into two main components: pre-hospitalisation and post-discharge. Services in the pre-hospitalisation space aim to manage and stabilise older people, in order to prevent hospitalisation. Services in the post discharge space aim to support older people transitioning from the hospital to the community setting and reduce their readmission risk. Data shows that for older people, approximately one in five unplanned admissions to hospital is medication related[9].



1. Reducing avoidable medication-related hospital admissions

As highlighted in the Royal Commission into Aged Care Quality and Safety: Final Report2, interdisciplinary teams must include pharmacists at the interface between the hospital system and the aged care system. The Medicine Safety: Take Care report[10] found that annually, there are 250,000 hospital admissions resulting from medication-related problems, costing the healthcare system $1.4 billion annually. Geriatric medicine pharmacists in an outreach role can contribute to reducing this.

A study at a major hospital in Victoria has found that the provision of Hospital Outreach Medication Review (HOMR) services has a valuable role in a clearly identified population that is at high risk of medication misadventure, which can include an adverse event, medication error or inappropriate use of a medicine. The study showed a 25% reduction in hospital admissions in patients aged 51-65 years following implementation of the HOMR service.



2. Reducing medication errors across transitions of care

Transitions of care is a great area of risk to patients, as recognised by the Australian Commission on Safety and Quality in Health Care in their report on Safety Issues at Transitions of Care.[11] If transitions of care are not undertaken properly, patients are at high-risk of readmission to hospital.

Following an inpatient admission, discrepancies in the discharge summary can occur, with the potential for these discrepancies being continued along each step in the Transitions of care. An audit at an Australian regional hospital demonstrated that almost half of these discrepancies are attributed to regular medications being omitted.[12] 29% of these had moderate potential clinical significance reiterating that improved communication around changes to medication regimes at transitions of care is essential in preventing harm to older people.

Without input from a pharmacist at the point of entry to a RACF, it has been observed that in the first 24 hours following discharge from hospital, over 18% of RACF residents have doses missed or significantly delayed, 61% do not have their medication charts updated and 38% do not have medications packed and available for the first dose.[13] As noted above, the potential for harm to older people is further compounded if there are discrepancies in the discharge summary following an inpatient admission.

3. Improving the safety and quality use of medicines

Existing medication regimens for residents in RACFs may not be reviewed regularly enough to optimise outcomes in older people. It is estimated that even after two years following RACF entry, only 49% of RACF residents have received a Residential Medication Management Review (RMMR).[14] A systematic review into the impact and outcomes of pharmacist-led medication reviews in Australian residential aged care facilities demonstrated success at identifying 2.7-3.9 medication-related problems per resident, with 84% of recommendations to resolve these accepted by the GP.3

Geriatric Medicine Outreach Pharmacists would also have a vital role in conducting clinical audits to define trends in prescribing and medication errors, as well as implementing system-wide strategy to improve practice.[3]

4. Providing advice on aged care policy setting and guidelines

Geriatric medicine pharmacists are very experienced and knowledgeable about providing comprehensive medication reviews, undertaking medication reconciliation, and supporting members of the interdisciplinary team. They play an important role in facilitating aged care policy setting and devising and evaluating guidelines.

Therefore, the impact of employing geriatric medicine pharmacists in outreach roles is likely to lead to improved patient outcomes through the increased uptake of Hospital Outreach Medication Reviews (HOMR) and regular review of medications across the transitions of care.

Core service elements for a hospital-based geriatric medicine outreach pharmacist service

Table 1: Core service elements for a hospital-based geriatric medicine outreach pharmacist service

It is suggested that the following core service elements are considered as best practice in the implementation of a hospital-based geriatric medicine outreach pharmacist service role.

Core Service Element	Description
Comprehensive medication review	• Accredited pharmacist-led where possible • Face to face assessment preferred, consider telehealth in rural and remote areas • Rationalisation of medication regime and recommendations for deprescribing where appropriate • Recommendations on medication that should be added or optimised • Ensuring medications prescribed align with current goals of care
Medication reconciliation	• Best Possible Medication History (BPMH) • Completed post-discharge and at transitions of care • Medication changes liaised with patient, carer, and all care providers (community pharmacy, GP, RACF, hospital specialist)
Providing education to members of the interdisciplinary team	• Targeted in-service or presentation • Correspondence to prescribers on latest evidence-based practice and new research • How to ensure medication safety in transitional care • Basic education for non-clinical staff on common medications

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Providing education to the patient and/or their carer(s)	• Explaining changes to medication regime in individualised way • Utilise teach-back method and check understanding • Discuss therapeutic rationale of any new and existing medication • Respecting preferences of the patient and/or carer following any recommendations
Liaising with other members of the interdisciplinary team	• This could include, but is not limited to: outpatient clinic, nursing staff, aged care staff, allied health professionals • Communicate medication related issues at interdisciplinary case conference and with hospital treating team (if available) which may impact treatment goals
Liaising with community pharmacy	• Ensure a continued medication supply • Facilitate set up of compliance aid if deemed appropriate • Communicate changes to therapy with community pharmacist and supporting rationale
Liaising with primary care prescribers	• Medication review recommendations communicated with primary care prescriber (Medication Management Review Report) • Communicating and clarifying therapy changes following hospital discharge for primary care prescriber • Liaise with primary care prescriber at all transitions of care • Provide prescribing assistance and recommendations to geriatricians and prescribers in the outreach team
Quality Use of Medicines (QUM)	• Reviewing medication related policies and procedures in line with quality care standards • Conducting clinical audits • Actively promote QUM by advising other members of outreach team on using medications safely and effectively • Promoting the use of non-pharmacological considerations where appropriate (e.g. antipsychotic stewardship, sleep hygiene)
Policy setting	• Reviewing medication related policies and procedures in line with quality care standards • Service development (including role description) and delivery
Ongoing follow up	• Post-discharge from outreach service and during outreach admission, liaise with patient/carer and primary care prescriber that therapeutic plan and recommendations are followed through

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Appendix 1

What could Geriatric Medicine Pharmacists integrated into the outreach space look like across Australia?
Services listed below may or may not have a geriatric outreach pharmacist employed in its program.

National

Community and Residential **Transition Care Programs** - program helps older people get back on their feet after a hospital stay. It provides short-term care for up to 12 weeks, including social work, nursing support, personal care and allied health care. https://www.health.gov.au/initiatives-and-programs/transition-care-programme

Queensland

Metro North Health **Post-Acute Care Services** - care for people who have been discharged from hospital or an emergency department but who still require short term care and support. Services are provided in-home, by telephone or can be clinic based. Services include education for falls prevention and medication management. https://metronorth.health.qld.gov.au/community/healthcare-services/post-acute-care-service

Residential Aged Care Support Services (RaSS) - A RaSS is a partnership between general practitioners (GPs), residential aged care facilities (RACFs), hospital and health services and community service providers. The RaSS is a single point of contact for RACF staff and GPs with residents who have acute health care needs, where these exceed the capability of the GP and RACF to manage independently. The service aims to support the best care for residents of aged care facilities, in the most appropriate location.

Victoria

Hospital Admission Risk Program (HARP) - HARP services provide specialist treatment, care planning, education and support to help people with chronic and complex health issues to manage independently in the community and reduce the risk of being admitted to hospital.

Hospital Outreach Medication Review (HOMR) services - Hospital-led outreach medication review services are currently provided by some major metropolitan public hospitals in Victoria and other states across Australia.

South Australia

Southern Adelaide Local Health Network, Geriatric Evaluation and Management (GEM) **GEM@Home** - service functions with a ‘home first’ principle by providing sub-acute hospital level care, goal directed therapy, and support to older people in the comfort of their own environment. Delivered by a specialist team of Geriatricians, Nurses and Allied Health geriatric specialists based at the Repat Health Precinct, the service has an in reach (Intensive Program) and an outreach (Community Program) component designed for older consumers with complex medical, function and/or psychosocial needs.

Western Australia

Complex Needs Coordination Team (CoNeCT) Pharmacy - Certain hospitals in Western Australia also run a Hospital Outreach Medication Review (HOMR) program known as **CoNeCT Pharmacy**, which provides a metropolitan-wide post-discharge service on referral for complex patients considered at high-risk of medication misadventure and who are unable to access timely community pharmacy services.

New South Wales

Transitional Aged Care Program (TACP) - provides short term care that aims to optimise the functioning and independence of older people after a hospital stay. It may include a package of services like low intensity therapy such as physiotherapy and occupational therapy, as well as social work, nursing support or personal care. It aims to enable older people to remain living at home after a hospital stay rather than enter residential aged care.

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