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Royal Australian College of General Practitioners

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Mr Daniel Pignatiello
External Relations & Policy Adviser
External relations, Communications & Marketing
NPS Medicinewise

E: DPignatiello@nps.org.au

Dear Daniel,

Re: NPS MedicineWise Quality use of medicines – topic selection consultation

The Royal Australian College of General Practitioners (RACGP) welcomes the opportunity to comment on the NPS MedicineWise consultation document which seeks stakeholder input on key themes regarding quality use of medicines (QUM). The RACGP offers the following suggestions on topic areas that NPS MedicineWise may wish to consider as areas of future focus.

1 Priority issues in QUM and stewardship

1.1 QUM Stewardship

There is ongoing need for efforts to monitor and manage inappropriately prescribed opioids and other drugs of addiction. Methods other than letters to high prescribers are needed.

The use of warfarin versus novel oral anticoagulants (NOAC) has also been identified by general practitioners (GPs) as an area of concern. Warfarin is the most widely used drug for long term anticoagulation therapy, however, it has a narrow therapeutic range, can be inhibited by other drugs and diet and therefore requires frequent blood monitoring for dose adjustment and control[1] . NOACs offer superior alternatives to warfarin, but switching is not without risk of adverse events[2]. This is an area of particular uncertainty and warrants further support and education for its management in general practice.

2 Areas of high unmet need/emerging challenges

2.1 Transitions of care where medication management is required

Paediatric transitioning to adult care, geriatric patients transferring to aged care, and transfer from hospital care into the community all have unique challenges for patient care.

For young people transitioning to adulthood, study and job requirements alter their engagement in chronic disease care and support. The cost of private care and medications may also alter their adherence and persistence with their treatment plan.

For geriatric patients transferring to aged care, if their regular GP is not able to continue to provide care, the loss of continuity of care poses potential issues. For example, there may be reduced communication between independent primary care / tertiary care providers and the aged care facility, which has potential for increased errors in dosing and administration of medicines. Furthermore, preventive activities including de-prescribing responsibility may also be overlooked. End of life care also requires careful and non-judgemental patient-

focussed approaches to medication use and support. In the aged care area, the RACGP has recently updated its Aged Care Clinical Guide (Silver book).

Transition of care issues are complex but efforts to address these issues across sectors and to develop systems, tools and education are needed. To address some of these issues, targeted GP education programs may be useful particularly where medication management is required.

2.2 High risk medicines

High risk medicines are associated with significant patient harm or death if they are misused or used in error. A key issue is that the rate of development and introduction of high risk medicines appears to be increasing, making it challenging for practitioners to be alert at all prescribing points. Increasing multi-morbidity further increases complexity in this area. Some key areas of focus are outlined below.

2.2.1 Prescribing software

Current prescribing software provides access to product information and some basic drug-drug interaction alerts. There is a need for systems to be in place to prompt monitoring including:

- evidence-based guideline-informed prescribing
- drug-disease interactions
- phamacogenetic interactions
- drug-lifestyle interactions
- cumulative drug interactions
- emerging phamacodynamic risks from changed renal function
- self-monitoring.

We are aware that some software systems, such as Primary Sense™ developed on the Gold Coast, are starting to address these deficiencies.

2.2.2 Medication governance

There are weak structures and few supports in place to support medication governance for low frequency, high-risk medicines in general practice. Non-dispensing pharmacists, as part of the practice team, could help address this gap. The RACGP values team-based models of care, and supports the inclusion of the general practice-based pharmacist role in a team-based model.

2.2.3 Patient safety and risk management

On the whole, not all general practices have the capacity, resources, knowledge, skills or systems in place to detect and act on patient safety events around high risk medicines. Therefore, facilitated significant event analysis and risk management would support practices and assist them to become learning organisations.

The Patient Safety Manual [3] outlines a structure and IT system to support meaningful significant event analysis and whole of sector improvement.

2.2.4 Shared care

Many high-risk medications and high-risk patients are managed by both GPs and non-GP specialists. Arrangements for monitoring investigations and patterns of care are often in place, but the monitoring plan, rationale, acceptable range and steps to be taken when out of range is often not articulated. Robust shared care arrangements with a shared health summary, clear lines of communication and responsibilities would improve QUM.

2.2.5 Suggested areas for improving the use of high-risk medicines

The RACGP highlights the following areas where the NPS MedicineWise may be able to assist in improving the use of high-risk medicines and/or preventing inappropriate use of these medicines:

- Support of IT system development to maximise the functionality of GP prescribing software to support QUM
- Identify and prioritise safety issues with high-risk medicines by identifying high risk prescribing / disease patterns in NPS MedicineWise data set and other data sources such as emergency department presentations, hospital admissions and coroners reports
- support non-dispensing pharmacists working as part of general practice teams
- Facilitate and support practices to engage in significant event analysis
- Develop guidance for shared governance of high-risk medications between non-GP specialists and GPs
- Advocate for systems that facilitate hospital discharge medications being sent to GPs and in a format that can be easily integrated and imported into general practice clinical software.

2.2.6 Partnership opportunities

There may be opportunities to work with general practice software vendors to improve on the current QUM computer decision support.

Partnerships could also be established to build the workforce and further define the role of non-dispensing pharmacists in general practice.

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2.3 Polypharmacy

2.3.1 Medication dose duplication

Some of the issues around polypharmacy and inappropriate prescribing include the increased risk of dose duplication. This risk is increased by:

- The increased dispensing of generic labelled items aimed at reducing costs to the consumer
- Consumers breaking continuity of their prescribing history through shopping at multiple pharmacy chains.

Inadvertent dose duplication can occur due to patients not being aware of similar drugs with differing names. The risk of dose duplication may be reduced by encouraging patients on five or more medicines to utilise one dispensing pharmacy.

Some further reduction of the risk of dose duplication may be achieved with specific attention to labelling medicines. Printing the non-proprietary / generic drug name in large print on the medicine label,[4] and the trade name in smaller font assists patients to become more familiar with the generic drug name. We are aware that positive reforms are underway in this area.

2.3.2 Reducing harm from inappropriate polypharmacy – a systems solution

NPS MedicineWise could assist in reducing harms from inappropriate polypharmacy through advocating for systemic and structural reforms. Whilst there is always a role for individual clinician focussed approaches (e.g. education), these alone are not the solution for systemic problems that contribute to inappropriate polypharmacy. Broader approaches that may result in benefits of reducing inappropriate polypharmacy include:

- Patient-centred medical home models of GP-led primary care including patient registration. Such a model will play a role in improving patient information flow (e.g. prescribing advice) from specialists in secondary and tertiary care to patients and their GP.
- Integration of non-dispensing pharmacists into the general practice team
- IT solutions that work across sectors, for example general practice and aged care facilities, that improve transparency of a patient's 'current' medicines.

2.4 Health literacy

2.4.1 Cultural diversity

Some of the issues/areas of need in health literacy, in the context of QUM and health technologies relate to cultural diversity. Whilst written English language resources (hard copy and online) are useful and important, translation of these into the common community languages is vital. In addition, the use of spoken word video resources should become more routine, as it cannot be assumed that people with low health literacy or English language proficiency can read.

2.4.2 Addressing health literacy

NPS MedicineWise could assist in addressing health literacy through identifying key issues to target in health education / promotion campaigns, which could be coordinated through general practice, and encourage patients to talk about their medicines with their GP. These topics for conversation could be underpinned by a broader program on de-prescribing. Examples of relevant topics include:

- Use of antibiotics for respiratory tract infections
- Not sharing medications
- Securing medicines in the home
- De-prescribing – asking your GP about your medicines

2.4.3 Opportunities for partnership and collective impact in health literacy

It will be important to coordinate any health literacy programs with the officers working on health literacy in Primary Health Networks.

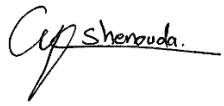
3 Additional priorities and opportunity for collaborative work

Specific challenges and gaps identified by the RACGP include:

- Sales of low value treatments in a low-regulation environment, such as complimentary medicines, which contributes to inappropriate polypharmacy
- A mismatch between subspecialist prescribing and generalist prescribing leading to harmful polypharmacy
- Lack of visibility and action for low frequency high-impact patient safety events because systems are not in place to detect and follow up with action.

Thank you again for the opportunity to provide feedback on this consultation. Please contact Mr Stephan Groombridge, Manager, eHealth and Quality Care on (03) 8669 0544 or at stephan.groombridge@racgp.org.au if you have any further queries.

Yours sincerely



Dr Ayman Shenouda
Acting President

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[3] https://research.bond.edu.au/en/publications/patient-safety-manual-for-primary-care

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