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CONFERENCE ABSTRACT

Integrating Clinical Advisory Pharmacists in the Health Care Home

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Introduction: Internationally governments have promoted general practices and community pharmacy working together more closely. Despite examples of co-location, this has not been particularly successful for a number of reasons, including issues of territoriality. There is growing interest in clinical pharmacists working in, and for, general practices.

Practice change: This is a change in the model of service delivery with the clinical pharmacist working within the multidisciplinary team of a health care home, and independent of a community pharmacy. This paper explores the changes occurring in the UK and Australia, and presents information of the roles and activities of the fledging clinical advisory pharmacist workforce in New Zealand. It includes the roles of prescribing pharmacists in primary care, using a collaborative prescribing model.

A survey of these pharmacists provides information on their roles and contributions to patient care, and creates opportunities for other health care homes to incorporate this resource into their practice.

Aim and theory of change: The aim of this change is to allow clinical advisory pharmacists, who by definition have postgraduate qualifications, to work to top-of-scope though working in the health care home, helping to reduce drug-related morbidity and mortality and therefore helping optimise medicines-related health outcomes.

The theory of change incorporates the concepts of the power / process and medical dominance models. This requires exposure to the new service, but additionally it has required recognition that the independent clinical advisory pharmacists have a different set of knowledge and skills.

Targeted populations and stakeholders: Most of the clinical advisory pharmacists in New Zealand are working in practices with vulnerable populations to improve access to optimal pharmacotherapy. This has been expanding, particularly over the last three years.

Highlights: The highlight of this service is the expansion and growing workforce with acceptance of the role of clinical advisory pharmacists within a health care home team and utilising their skills to improve person and whanau care. Evaluations of the different services has shown beneficial outcomes.

Sustainability, transferability: With the changing workforce and increasing multidisciplinary teams in health care homes, this model of clinical pharmacist service delivery is very transferable, although requires a transfer of funding and investment for five years to establish it fully and achieve a critical mass.

Conclusions: Independent clinical advisory and prescribing pharmacists are a viable way of integrating services into the health care home. We can learn from international evidence, but also the growing evidence in New Zealand.

Lessons learnt:The clinical advisory and prescribing pharmacists bring a different skill set and focus into the health care home, but exposure is required to help understand the benefits achieved.

References:

1. Ritchey F, Raney M. Medical role-task boundary maintenance: physicians' opinions on clinical pharmacy. Med Care. 1981;19(1):90-103.

2. Adamcik B, Oppenheimer E, Brown P, et al. New clinical roles for pharmacists: a study of role Expansion. Soc Sci Med. 1986;23:1187-1200.

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