



# Leading healthcare reform through curriculum change

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**Professor of Clinical Pharmacy**

**Faculty of Pharmacy and Pharmaceutical Science, Monash University**



## Alfred Health

- The Alfred Hospital
- Caulfield Hospital
- Sandringham Hospital
- Melbourne Sexual Health



**TheAlfred**



**Sandringham**  
HOSPITAL



**Caulfield**  
HOSPITAL

## The Alfred Medical Research & Education Precinct (AMREP)

- Alfred Health
- Baker IDI Heart & Diabetes Institute
- Deakin University
- Burnet Institute
- Latrobe University

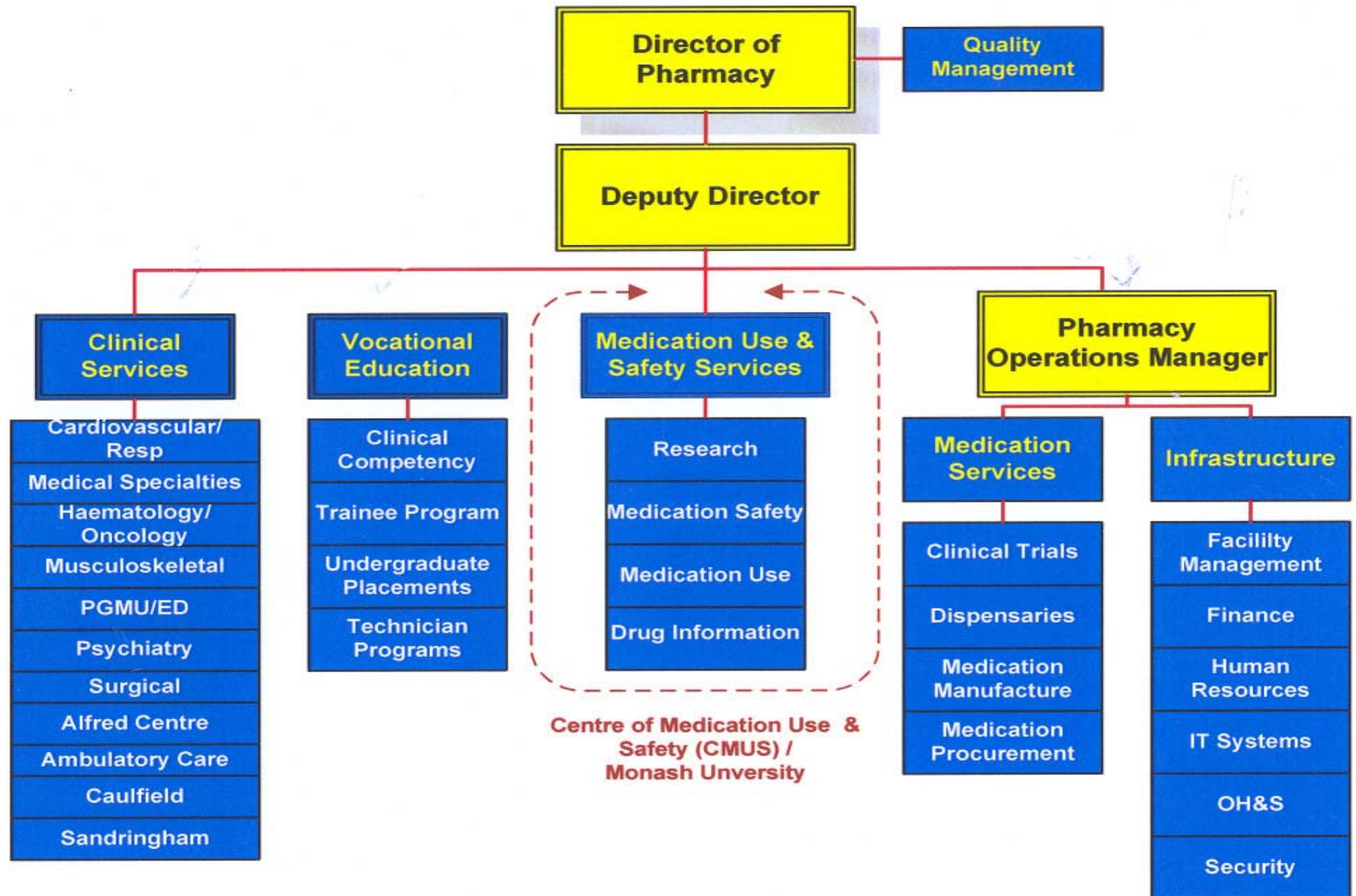


**MONASH** University  
Pharmacy and Pharmaceutical Sciences

## Clinical Organisation

Programme
Cancer & Medical Specialties
Cardiothoracic and Intensive Care
Emergency and Acute Medicine
Pathology
Pharmacy
Psychiatry
Radiology
Rehabilitation, Aged and Community Care
Surgical Services

## Pharmacy Department



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# Leading healthcare reform through curriculum change

## Prato 2037



# Is this the future of pharmacy?

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- Therapeutic decision making will be delegated to pharmacists
- Physicians will relinquish dosing to pharmacists
- Institutional practice will require periodic recertification
- Institutional practice will be composed of multiple tracks
- Hospital accreditation will require clinical pharmacy services in defined areas of practice
- Turf conflicts between nursing and pharmacy will become more intense
- Conflicts between nurse practitioners and clinical pharmacists will increase
- Pharmacist will have the legal prerogative to prescribe

# Barriers to advancement?

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- Lack of widely agreed-upon philosophy of practice in pharmacy
- Lack of consensus on what the standard of practice ought to be
- Lack of consumer demand for clinical pharmacy services
- Inadequate substantiation of the value of clinical pharmacy services
- Ill-defined priorities in the provision of clinical pharmacy services
- Lack of continuity of pharmaceutical services
- Inadequate systems of rewards
- Limited expectations of other health professionals have of pharmacists
- Failure of pharmacists to remain competent
- Lack of appropriate technical support in pharmacy
- Pharmacy directors are unable to provide effective leadership

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# Leading healthcare reform through curriculum change

## Prato 2037....really!!

Gourley DR, Hadsall RS, Gourley G, Fine DJ, Wiener M. ASHP members' concepts of institutional pharmacy in the year 2000. Am J Hosp Pharm 1985; 42: 96-101



# Prato 2011

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*Most important thing we ought to be focusing on?*

***“search for our identity....whatever that is.....”***

***“Abandon curriculum”***

***“professional identity...who we are....”***

***“academic minds need some direction....”***

***“ditch teaching.....let them play”***

***“change teaching approach....”***

***“show excellence.....”***

# Prato 2011

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*“show excellence.....”*

(but not limited to)

**Healthcare practitioners with expertise in medication management**

# Resistance to change in practice setting

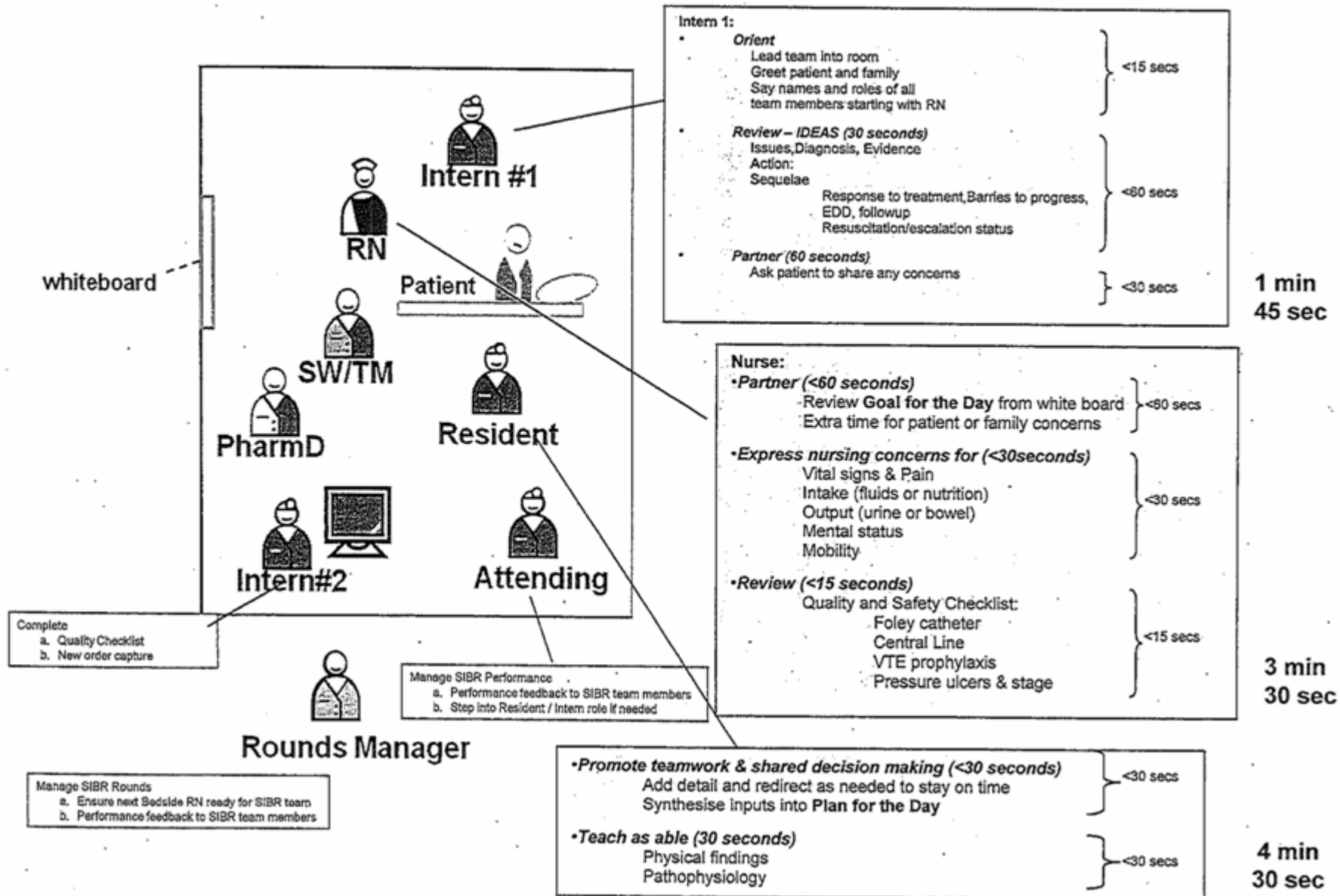
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Ward based pharmacists

Versus


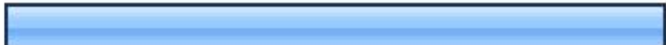
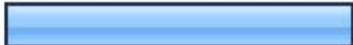
Unit based pharmacists

# Structured Interdisciplinary Bedside Rounds<sup>1</sup> (SIBR)



# Resistance to change in practice setting

20. Do you think that any of the following barriers to implementing these roles into your job as a pharmacist exist? (Please tick all the statements that you feel apply)

		Response Percent	Response Count
Time constraints		84.0%	21
Overlapping with other healthcare professional's job roles		76.0%	19
Lack of confidence with conducting simple clinical tests on patients		40.0%	10
Other (please specify)			4
answered question			25
skipped question			18

# Is this the future of pharmacy curriculum?

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1. Students who know what the profession is.....before enrolling...not years after enrolling
2. Students enrolled who have the motivation to become healthcare professionals
3. Students really screened/culled at entry level
4. Practice placements with patients in the first month of starting undergraduate degree...and every year after that
5. Undergraduate clinical content only delivered by practising clinicians
6. Electives...choice within the program
7. Different track for those only interested in small business model
8. ...5% of other.....increased to 20%
9. White space is known as something in the brain
10. Graduates with attributes that will make a difference in the future
11. Graduates who can engage patients...graduates who believe they are health professionals that make a difference
12. Graduates who can make independent decisions
13. Curriculum that is responsive to change
14. A sense of urgency and a sense of passion

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(but not limited to)

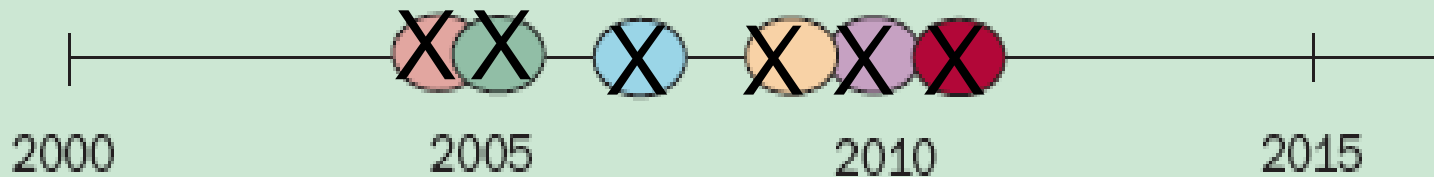
Healthcare practitioners with expertise in medication management



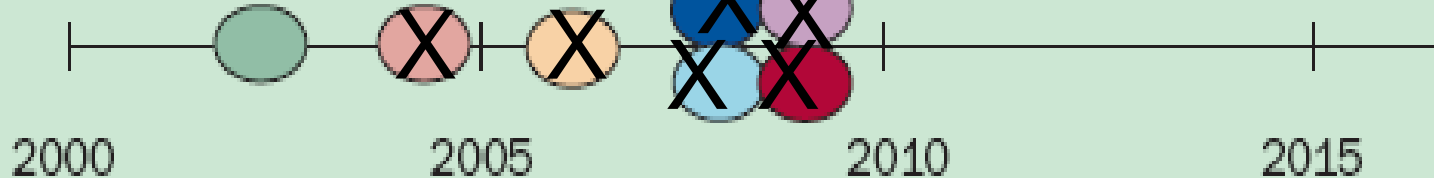
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# It's not about the drug

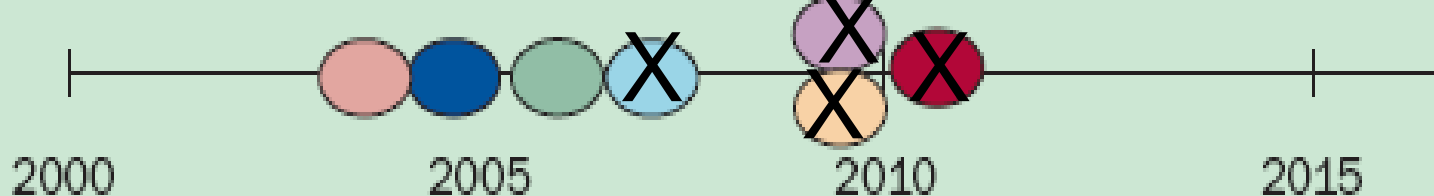
## Breast cancer



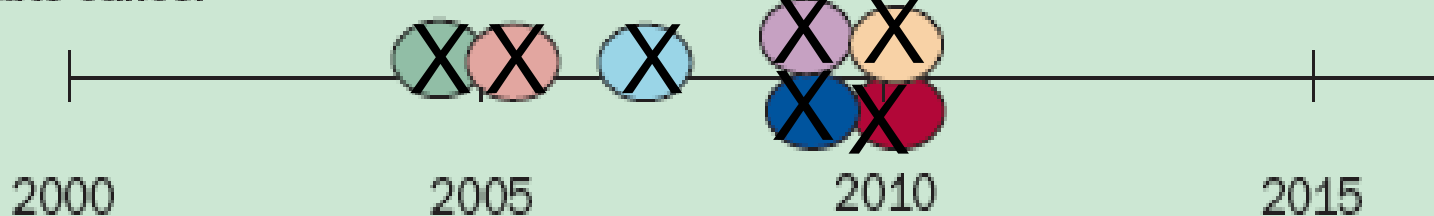
## Lung cancer



## Colorectal cancer



## Prostate cancer

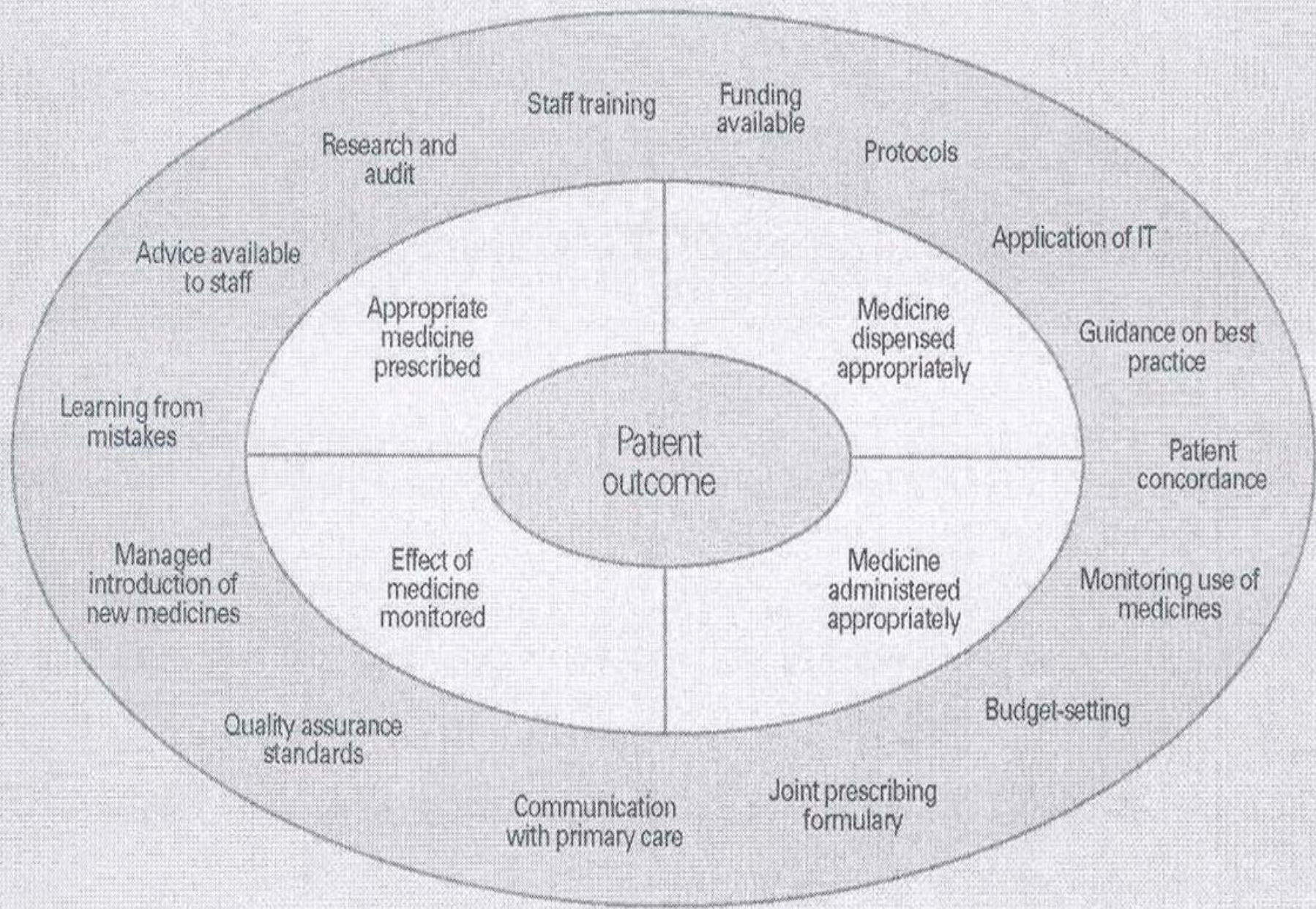


- |                         |                      |
|-------------------------|----------------------|
| ■ Monoclonal antibodies | ■ Apoptosis inducers |
| ■ Vaccines              | ■ Antisense therapy  |
| ■ Antiangiogenic agents | ■ Gene therapy       |
| ■ Kinase inhibitors     |                      |

# How much should we focus on new medications?

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>98% of all medications initiated in acute care hospitals  
have been on the market for > 5years



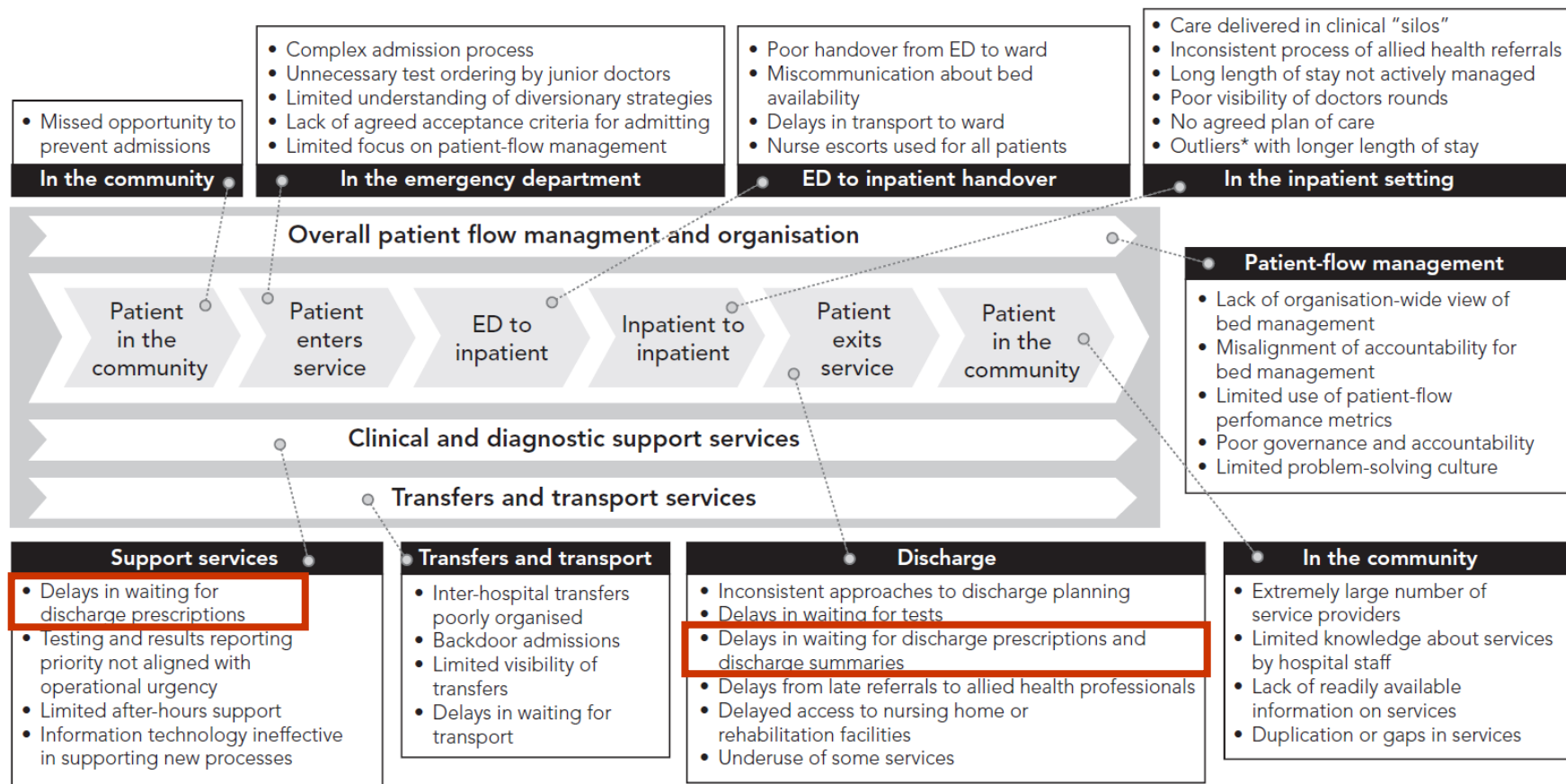




## Health services under siege: the case for clinical process redesign

Tony J O'Connell, David I Ben-Tovim, Brian C McCaughan, Michael G Szwarcbord and Katherine M McGrath

### 3 Problems and disconnections identified along a patient journey



ED = emergency department. \* Patients admitted to an available bed in a ward that is not the designated ward for their condition.

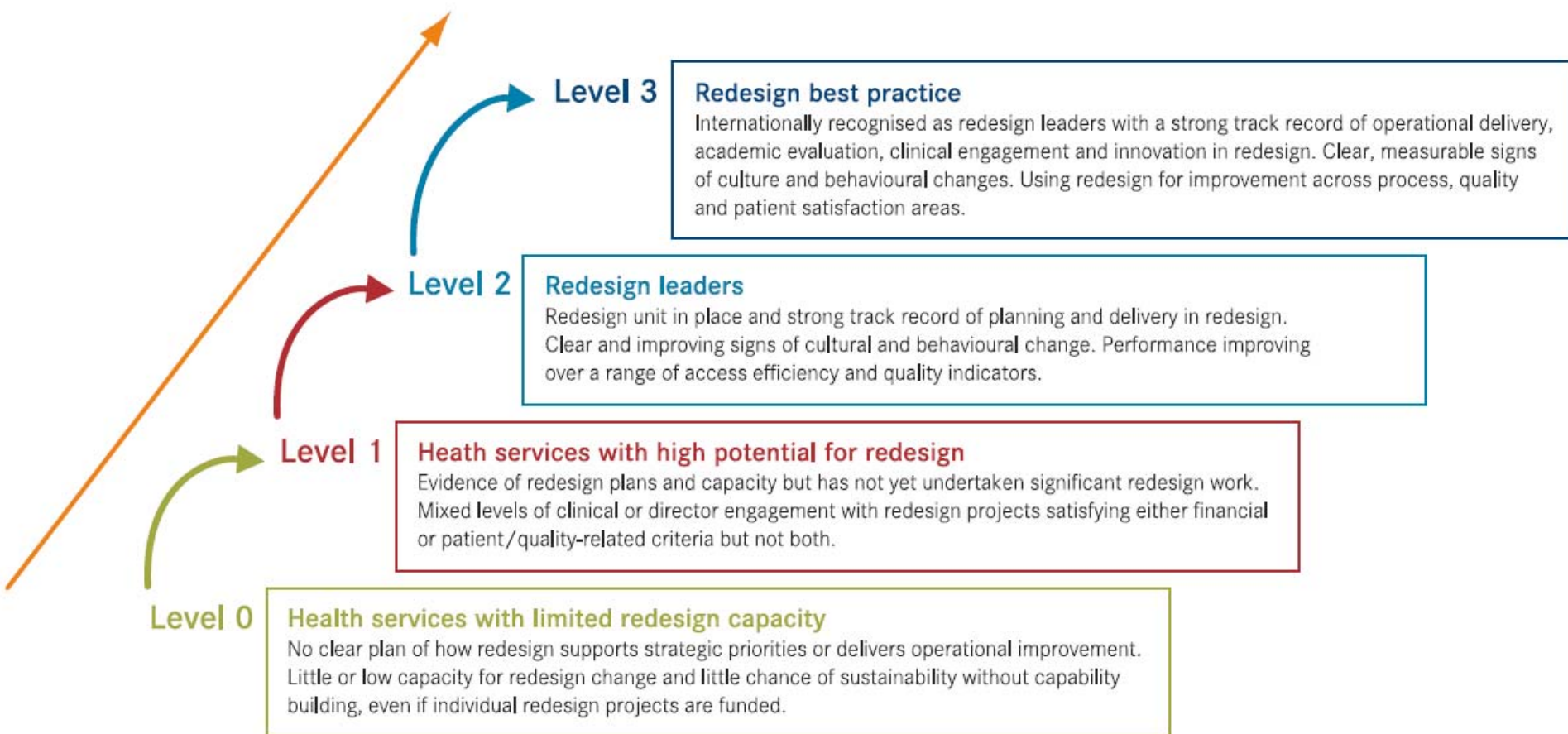
# Leading healthcare reform through curriculum change

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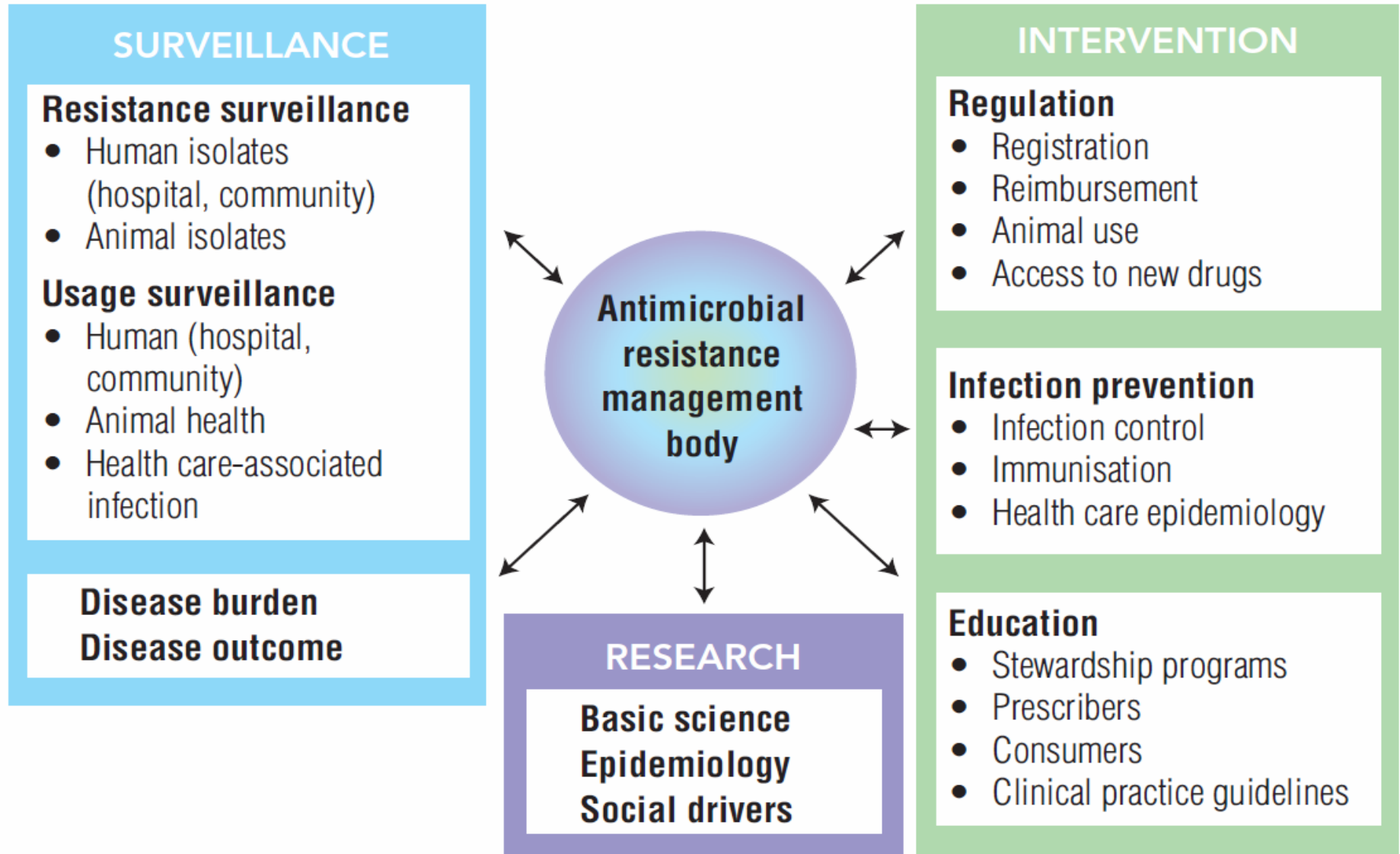
- Focusing on innovation and change management

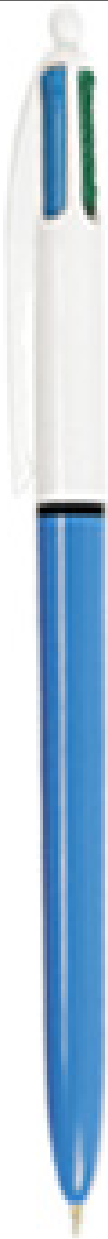


Figure 3: Levels of redesign capability



# 1 An agenda for addressing antimicrobial resistance





# Balanced adoption of technology



# Challenges of Adoption of Technology in the Acute Healthcare Setting

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## Implementation

- Technological (*i.e. system applications*)
- Organisational process change (*i.e. Workflow redesign*)
- Human factors (*i.e. user-friendliness*)
- Project management (*i.e. achieving project milestones*)

**Chaudhry B, et al. Ann Intern Med 2006; 144:12-22.**

# Challenges of Adoption of Technology in the Acute Healthcare Setting

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## Evaluation

### Dimensions of care

Effectiveness

Efficiency

Safety

Access

### Effect to evaluate

Adherence

Surveillance

Errors

Time to care

Utilization of care

Time to utilization

Time utilization

Implementation costs

# Challenges in implementing prescribing: experiences in Victoria

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**Software functionality**

**Difference in practices from the US**

**Required enhancements**

**Third party vendors**

**Functional evaluation**

**Medication datasets**

**Decision support**

**Legislative and regulatory issues**

**Business case**

**Timelines and political constraints**

**Sector and clinical expectations**

**Data**

**Evaluation**

# Leading healthcare reform through curriculum change

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- Focusing on innovation and change management

- Working together to:

keep an eye on the big picture

tackle the tough stuff

drive rapid spread of knowledge

facilitate swift implementation

ensure sustainability of evidence-based solutions.



## Health system policy

- *Victorian health services policy and funding guidelines 2010-11*
- *Directions for your health system – Metropolitan Health Strategy*
- *Rural directions for a stronger healthier Victoria – Update of Rural directions for a better state of health*
- *Victorian clinical governance policy framework – Enhancing clinical care*
- *HealthSMART participation policy*

## Program-specific policy

- *Because mental health matters – Victorian Mental Health Reform Strategy 2009-19*
- *Victoria's Cancer Action Plan 2008-2011 – Innovation in care-saving lives*
- *Close the Gap: Indigenous Health Equality Summit – Statement of Intent*
- *Better Faster Emergency Care – Improving emergency care and access in Victoria's public hospitals*
- *Improving care for older people – A policy for Health Services*
- *Victoria's intensive care services: Future directions, 2009*
- *Patient-centred surgery: strategic directions for surgical services in Victoria's public hospitals, 2010-2015.*
- *Victorian public hospital specialist clinics - Strategic framework*
- *Future directions for Victoria's maternity services*

## 2010-11 State Budget initiatives

Key initiatives of the 2010-11 State Budget will create capacity to meet growing demand for hospital services and include funding to:

- expand inpatient services to treat additional patients and open additional beds in acute, sub acute and critical care services
- meet demand for radiotherapy, chemotherapy, renal dialysis
- invest in mental health services and support mental health service redevelopment and reform
- expand palliative care, post-acute care and provide additional sub acute transition care places
- expand the Hospital Admission Risk program, including the Residential In-Reach Program, and provide additional community rehabilitation services
- treat extra elective surgery patients
- support new health, aged care and community services infrastructure
- increase the health workforce and support health workforce reform
- provide ongoing ambulance services

Consultation Paper on the

**Draft**

# **National Safety and Quality Health Service Standards**

August 2010

There are ten Standards in total. The first five standards are:

- ***Governance for Safety and Quality in Health Service Organisations***, which provides the framework for Health Service Organisations as they implement safe systems
- ***Healthcare-Associated Infection***, which describes the standard expected to prevent infection of patients within the healthcare system and to manage infections effectively when they occur, to minimise their consequences
- ***Medication Safety***, which describes the standard expected to ensure clinicians prescribe, dispense and administer appropriate and safe medication to informed patients
- ***Patient Identification and Procedure Matching***, which specifies the expected processes for identification of patients and correctly matching their identity with the correct treatment.
- ***Clinical Handover***, which describes the requirement for effective clinical communication whenever accountability and responsibility for a patient's care is transferred.

The five new draft Standards are:

- ***Partnering for Consumer Engagement***, which creates a consumer-centred health system by including consumers in the design and delivery of quality health care
- ***Blood and Blood-product Safety***, which sets the standard to ensure that the patients who receive blood and blood products are safe
- ***Prevention and Management of Pressure Ulcers***, which specifies the expected standard to prevent patients developing pressure ulcers and best practice management when pressure ulcers occur
- ***Recognising and Responding to Clinical Deterioration in Acute Health Care***, which describes the systems required by health services responding to patients when their clinical condition deteriorates
- ***Preventing Falls and Harm from Falls***, which describes the standards for reducing the incidence of patient falls in Health Service Organisations.

# The Victorian health system in 2022

Responsive to people's needs

Rigorously informed and informative

Pathways that are responsive to people's needs

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- **Develop a system responsive to peoples needs**
- **Expanding service, workforce and system capacity**
- **Increasing system financial sustainability and productivity**
- **Implementing continuous improvements and innovation**
- **Increasing accountability and transparency**
- **Utilising e-health and communication technology**

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# Independent professional responsibility for health outcomes

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All clinical pharmacists have a clinical outcome indicator

% drug doses appropriately adjusted for CRRT

% patients prescribed appropriate antiplatelet therapy at discharge following ACS

% of patients receiving 1st dose of rivaroxaban within 6-10 hours of surgery \*

Error prone abbreviations %orders(ACHS)

< 10 days to reach therapeutic INR after warfarin initiation \*

% All drugs requiring TDM have documented monitoring plan and/or appropriate management plan \*

% of PGMU patients with IHD on an antiplatelet \*

% patients prescribed antipsychotics at levels below chlorpromazine equivalents of 1000mg per day \*

% of Vascular patients with PVD on an antiplatelet

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