PHARMACEUTICAL SOCIETY OF AUSTRALIA
NATIONAL PALLIATIVE CARE PROJECT SERVICE MODEL PILOTS

Megan Tremlett [1]
1. Pharmaceutical Society of Australia, Deakin, ACT, Australia

KEYWORDS

Palliative care pharmacist, interdisciplinary, community-based palliative care, embedded, medicines safety

EXECUTIVE SUMMARY

Despite the known complexity of medication regimens of many patients with palliative care needs, and the associated high risk of medication-related problems, pharmacists in Australia are not funded consistently or reliably to work within community-based interdisciplinary palliative care teams. Further, there is a lack of evidence describing the role and impact of pharmacists in this setting.

The Pharmaceutical Society of Australia's National Palliative Care Project 2023-2026 Service Model Pilots explored embedded palliative care pharmacist models within six community-based Specialist Palliative Care Service teams to optimise medicines use and support patients, their family/carers and the health professionals involved in patient care.

INTRODUCTION

Patients receiving palliative care are often on complex medication regimens to manage their symptoms and comorbidities, and at high risk of medication-related problems. Specialist community palliative care is a cost-effective alternative to hospital-based care and improves outcomes for patients and their carers through enhanced communication and improved symptom management. As medicines experts, appropriately trained pharmacists are well placed to support people with palliative care needs, their family/carers and the broader interdisciplinary palliative care team. In Australia, however, pharmacists are not currently funded consistently or reliably to work with primary care interdisciplinary teams to support people with palliative care needs in the community. Further, there is a lack of evidence describing the role and impact of pharmacists in this setting.

The Pharmaceutical Society of Australia's (PSA's) National Palliative Care Project 2023-2026 Service Model Pilots explored embedded palliative care pharmacist models within six Specialist Palliative Care community-based teams across Victoria, New South Wales and Queensland. Each pilot pharmacist was embedded in their respective team for one day a week over a 12-month period, with the aim of optimising medicines use and supporting patients, their family/carers and the health professionals involved in patient care.

HIGHLIGHTS

- Successful pilot implementation within six Specialist Palliative Care teams
- Complexity of patient medication regimens and symptom burden captured
- Palliative care pharmacist activities in community teams described in detail
- Service models identified, including triggers for pharmacist involvement
- Strong positive feedback from health professionals working with the pilot pharmacists

METHODOLOGY/ PROCESS

PSA engaged six Specialist Palliative Care Services (SPCSs) to participate in the pilots, with site selection recognising the diversity of models of community-based palliative care across Australia. This included SPCS teams servicing populations in metropolitan, regional and remote locations, and operating under a range of governance models. In doing so, PSA aimed to deliver an impact assessment that could be generalised to other Australian SPCS sites/settings in the future.

In collaboration with key representatives (or 'champions') from each SPCS pilot site team, PSA recruited pharmacists for the roles through an expression of interest and subsequent interview process, with pilots commencing from March 2025.

Quantitative Data

Upon commencement, the pilot pharmacists recorded their day-to-day activities by means of two bespoke digital interaction logs developed by PSA. One log captured the pilot pharmacists' interactions with patients/carers, and the other their interactions with the health professionals involved in patient care (including within the SPC team and from across the broader community/health neighbourhood).

Qualitative Data

Qualitative feedback on the impact of the pilots was sought from the pilot pharmacists themselves and the teams they were embedded within, as well as other health professionals who had interacted with the pilot pharmacists. This was achieved by means of online surveys, semi-structured interviews and face-to-face workshops. PSA did not seek Ethics approval to reach directly to patients and carers for feedback.

RESULTS/ OUTCOMES

Health Professional Interactions

A total of 858 interactions between the pilot pharmacists and health professionals were recorded. As shown in Figure 1, the highest number of interprofessional interactions was with nurses, followed by Specialists, pharmacists, doctors and allied health professionals. These interactions took place predominantly within the pilot site, noting that virtual service delivery was a deliberate feature of one of the pilots which serviced a very large geographic area (see Figure 2); the most common means of interaction was face-to-face, except for the pilot which utilised a telehealth delivery model. The primary reason for interaction was to discuss a specific patient, with other reasons including to establish an interprofessional connection, an ad-hoc query, team meeting, quality improvement activity, planned education and to support a patient transition of care (refer to Figure 3). As showcased in Figure 4, a wide range of activity outcomes from the pharmacists' interactions with health professionals were captured, highlighting their significant value within the team.

Patient/Carer Interactions

A total of 295 interactions between the pilot pharmacists and patients/carers were recorded. While the majority of interactions involved patients who were aged 65 or older, it is noteworthy that 29% were <65, a cohort known to experience challenges accessing funded care in the community. Further, 9% of patients were found to live alone without any support, highlighting the importance of the pharmacists' availability for home visits. The main reason for interaction was the patient being identified by the team as requiring pharmacist input, with the second most frequent reason being to provide support in relation to a transition of care. Figure 5 highlights the complex needs of the patients the pilot pharmacists interacted with, as indicated by Australia-modified Karnofsky Performance Score (AKPS) measures, presence of distressing symptoms, and high incidence of polypharmacy or superpolypharmacy. While formal measures of hospital avoidance were not used in the pilots, this complexity has historically been associated with increased use of the health system including Emergency Department presentations and hospitalisation. Figure 6 demonstrates the significant breadth of outcomes of the pharmacists' interactions with patients and carers. In almost 80% of interactions, the pharmacists felt their interaction increased the knowledge and confidence of the patient and/or carer with palliative care medicines.

Qualitative Feedback

Qualitative surveys were completed by 48 health professionals, with Figure 7 showcasing their perceptions of the value of the pilot pharmacists. A range of open-ended questions were also asked in the survey, and in pilot team meetings, with overwhelming support for these models of care to be continued and rolled out nationally.

CONCLUSION

PSA's National Palliative Care Project 2023-2026 Service Model Pilots successfully demonstrated the breadth of expert contribution of embedded pharmacists to community palliative care and the significant impact on patients, their families/carers and the interdisciplinary palliative care team.

High rates of patient symptom burden, particularly pain and breathlessness, combined with high levels of polypharmacy and caregiver reliance, created frequent opportunities for pharmacist intervention. Through medication reconciliation and optimisation, combined with education and quality improvement initiatives, the pilot pharmacists strengthened medicines safety, enhanced medication-related confidence, and contributed to potential reductions in avoidable hospital use. These findings support continued and expanded integration of pharmacists within community-based interdisciplinary palliative care teams.

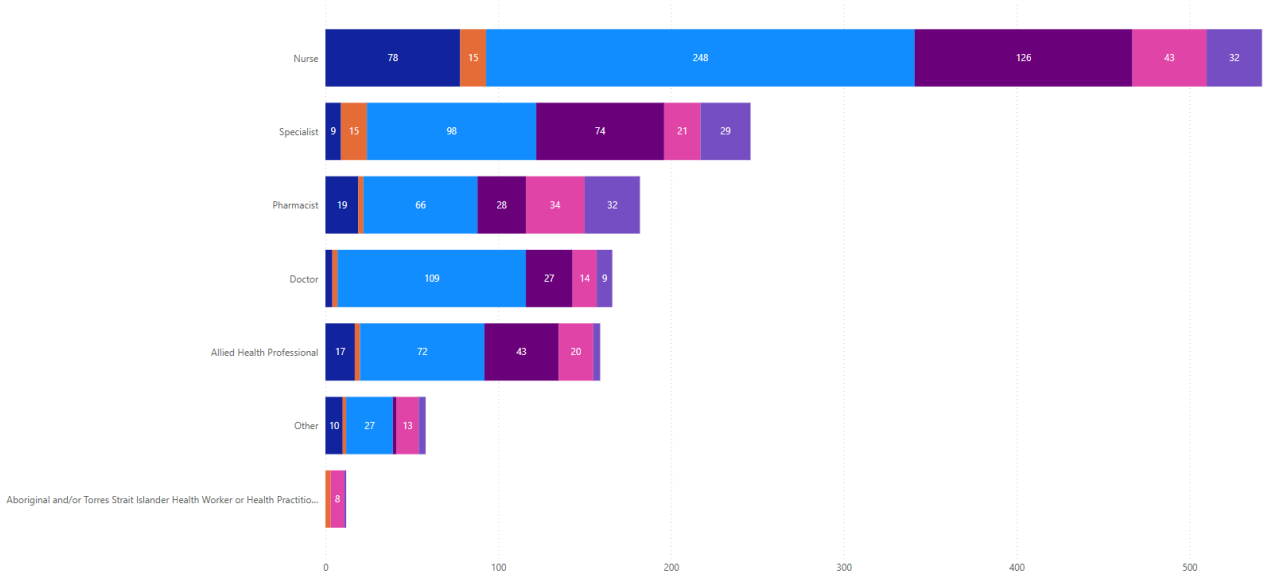

Figure 1. Health professionals the pilot pharmacists interacted with

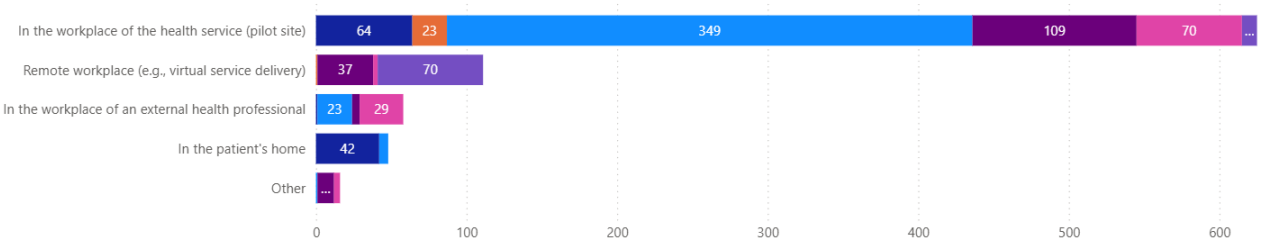

Figure 2. Locations of health professional interaction

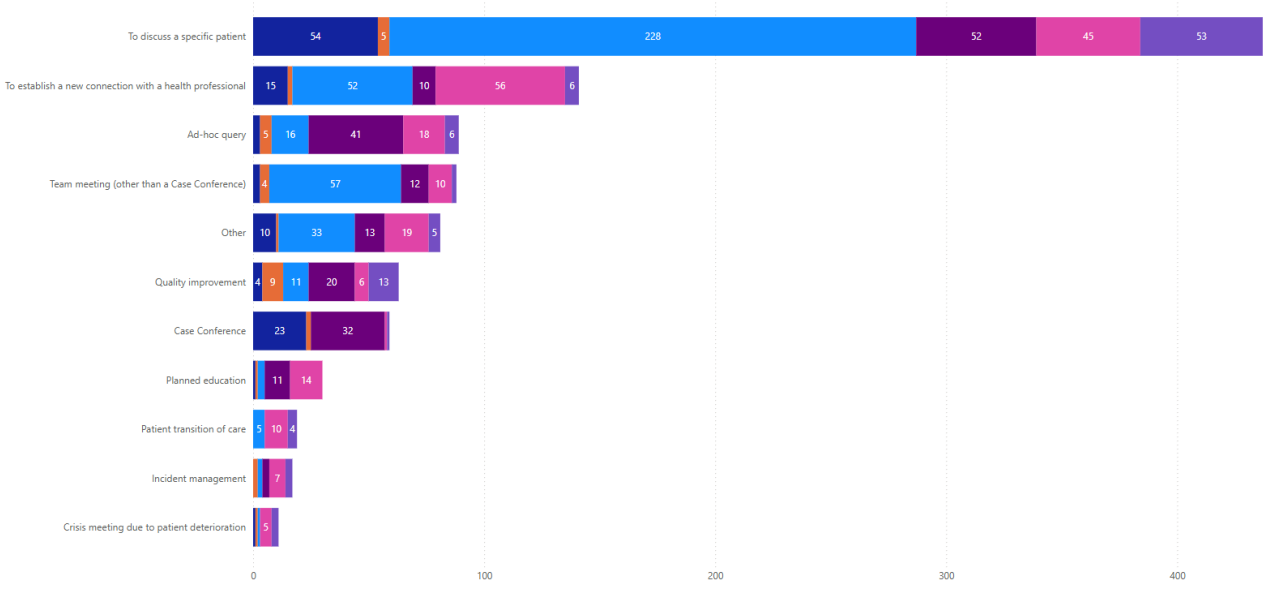

Figure 3. Reason for health professional interaction

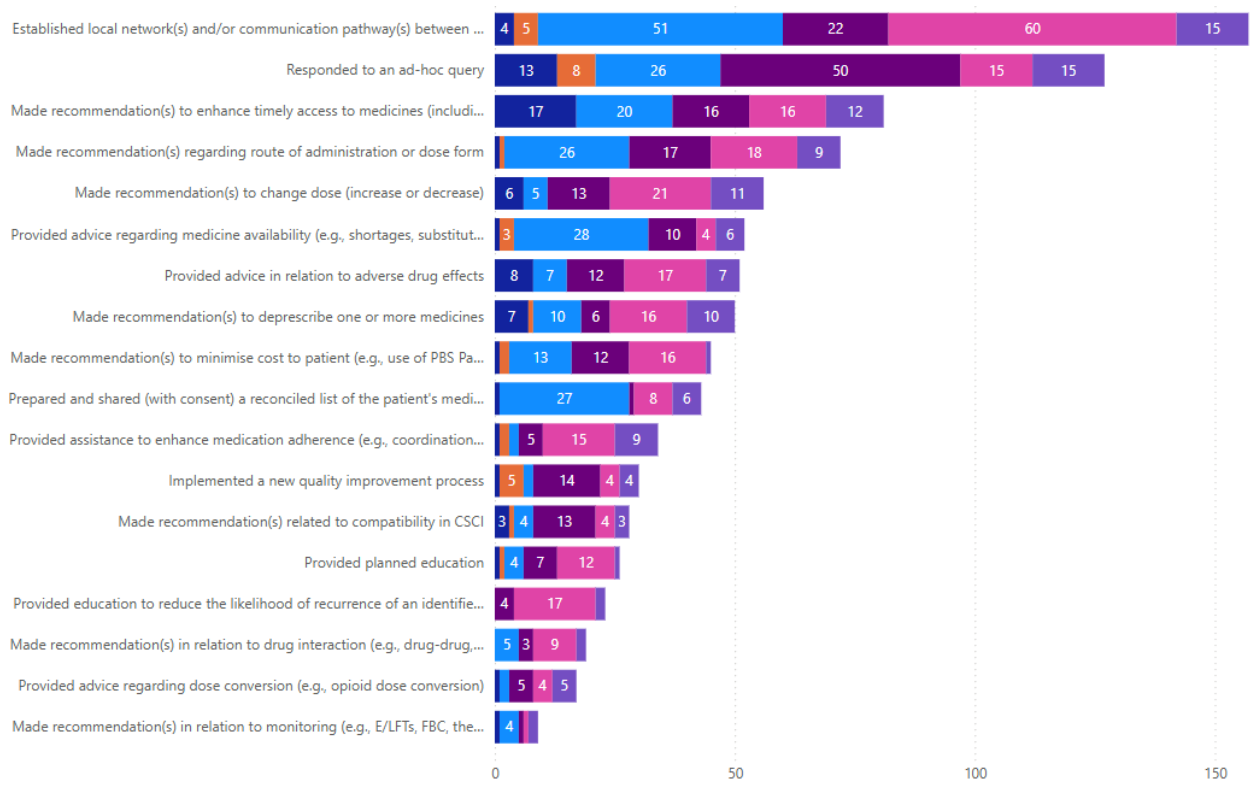

Figure 4. Outcomes of health professional interaction

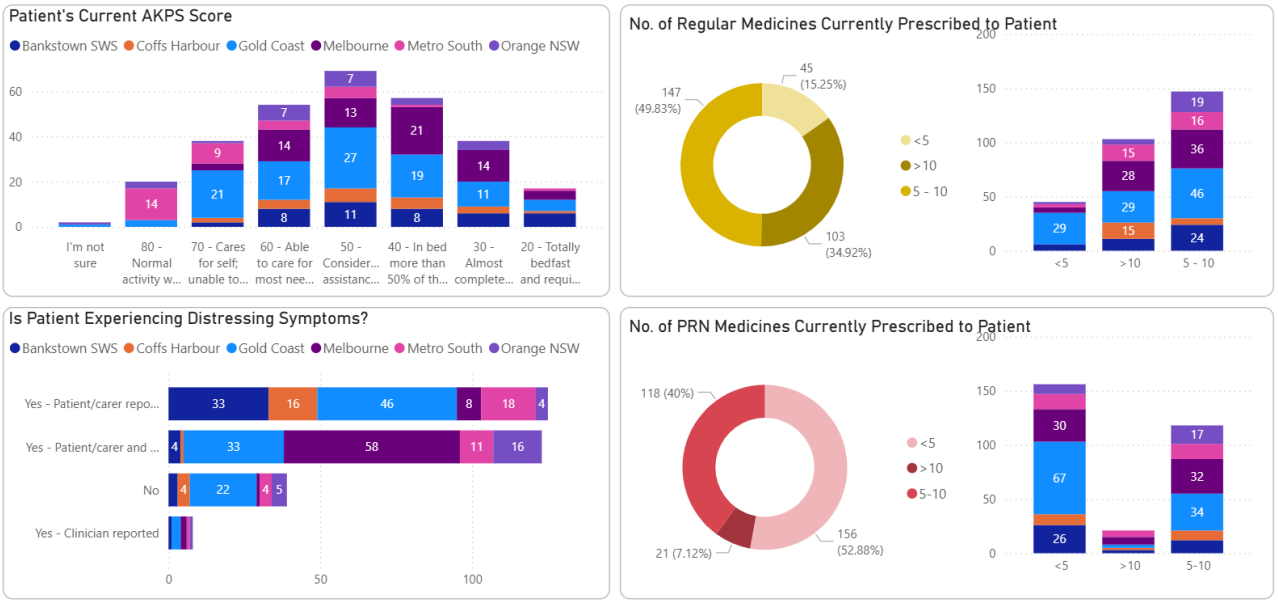

Figure 5. Indicators of complexity: patient functionality, symptom burden and polypharmacy

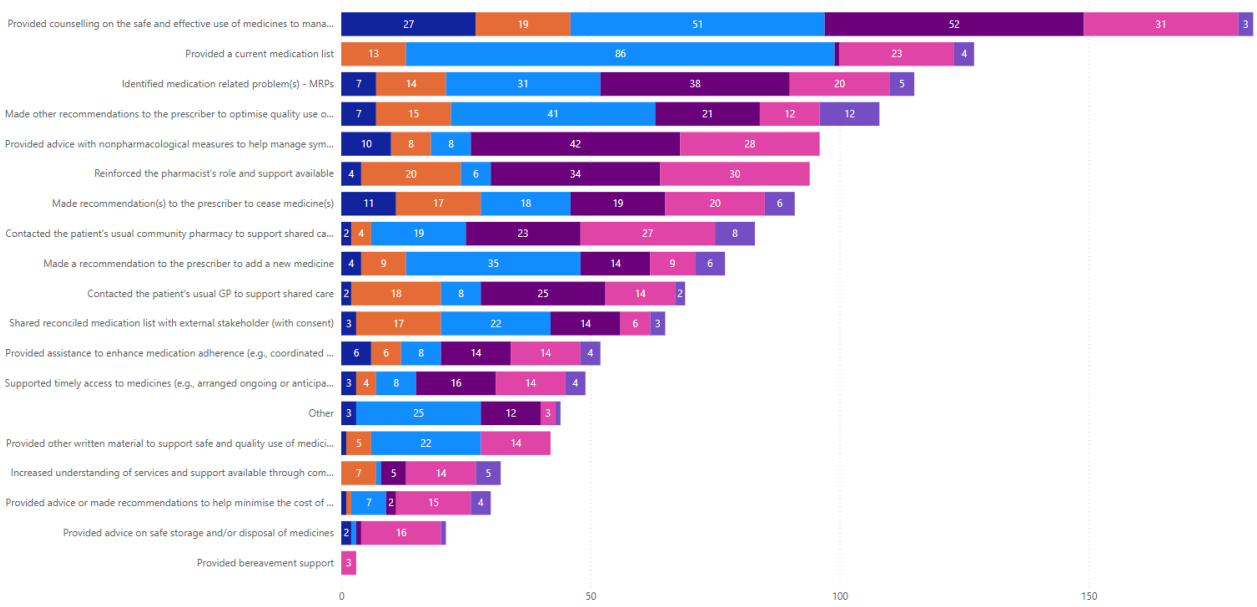

Figure 6. Outcomes of patient/carer interactions



Figure 7. Health professional perceptions of the value of the pilot pharmacist